

Seven Layers of Skin: The Practice of Childbirth in the Context of High Cesarean Section Rates in Brazil

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September 2015

Thesis submitted as part of the Master of Philosophy Degree in

International Community Health

ABSTRACT

This research explores the experience of childbirth in the context of high cesarean sections rates in Brazil. Ethnographic methods were used to collect data through interviews and narrative theory served as analytical tool. Through descriptions of events experienced by the women interviewed, this study has shown that the practice of childbirth in Brazil happens within a biomedical view of the body. The practices experienced by the women and the policies promoted by the Brazilian government evidence a strong influence in the way birth is carried out in the country, embedded in concepts developed in the last century, namely the ‘medicalization’ critique and the ‘natural’ childbirth movement. Feminist movements in Brazil are described as having an effect in consolidating these concepts within the government and society at large. ‘Humanization’ as it is promoted in Brazil explicates a movement towards ‘de-medicalization’ of the birth event. This process was analyzed as having both benefits and drawbacks. The findings of this research provide relevant insights into addressing the way childbirth is carried out in Brazil, bringing new perspectives to how we are to approach health care towards pregnant and birthing women.

ACKNOWLEDGMENTS

Like most of the women I interviewed, who have stepped into the enterprise of motherhood and divide their time between their children and work or studies, I wrote this thesis between breastfeeding and books. Time is valuable when most of the day is used in caring for children. I can only express my immense gratitude to the mothers I talked to, for using hours of their day devoted to me. Also, by being a mother myself, I know how precious and intense the experience of childbirth can be. I am immensely grateful and honored by having had the opportunity of listening to your stories. Thank you! I want to extend my thanks also to the nurse, doula and doctor I interviewed for their time and inputs, and for inspiring me by their devotion to a better childbirth in Brazil.

I want to especially thank my supervisor Benedikte V. Lindskog; for her patience to see this project through to completion after more than two years; for her guidance into the field of social sciences; for discussing long chapters and correcting my endless orthographic mistakes; for support and inspiration as a researcher and person.

In addition, more people deserve my gratitude. My co-supervisor in Brazil, Tânia Maria Santos Pires, for her help and advice concerning the Ethics Committee. Terese Eriksen, for her assistance with registrations, and for her intermediations with the Department of Community Medicine that provided me with the extended time to finish this project in a slower pace. Ane Haaland and Line Marie Løw for their constructive comments and advice when this research was just an idea. My friends in the Masters - Laura, Anna, Chun-An and Annemiek - for their continuous encouragement throughout pregnancy and after birth. My son's grandparents – Lucia, Paulo, Silêda and Valdir - for their caring love and for providing him with play, food and sleep during my fieldwork and while I was writing this thesis. To you all, thanks a lot.

Finally, I want to dedicate this work to my boys. I express my deepest gratitude to my husband Maicon, with whom I made the decision of having our first child while taking this Masters. All along he has provided me with motivation after reading my chapters, fruitful discussions while cooking, and peace of mind while staying with our child. And to my son Oliver, whom I thank for being.

Foremost, I thank God for his grace.

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LIST OF ABBREVIATIONS

SUS	Unified Health System (<i>Sistema Único de Saúde</i>)
INAMPS	National Social Security Health Care Institute (<i>Instituto Nacional de Assistência Médica e Previdência Social</i>)
UNFPA	United Nations Population Fund
PAISM	Integral Assistance to Women's Health Program (<i>Programa de Assistência Integral à Saúde da Mulher</i>)
PHPN	Program for Humanization of Prenatal and Childbirth Care (<i>Programa de Humanização no Pré-Natal e Nascimento</i>)

CHAPTER ONE: OPENING

So, I hear a lot: “Normal birth is something archaic. Why are you going to feel pain if you can just have a surgery?” Then I say: “Just a surgery? It is seven layers of skin, man! Are you crazy?”

Joyce, who had a normal birth in a public hospital

Everything started with cesarean sections. The prevalence of high rates of cesarean sections in Brazil has been widely discussed in scholarly literature, and it has roused my curiosity towards childbirth in the country. Furthermore, the rates of cesarean section have been pointed out by international health organizations and it has contributed to a raised awareness within the government and among civil society in the country. Cesarean sections in Brazil are indeed very common.

The quotation above illustrates to some extent how I perceive the influences of cesarean sections rates in Brazil. According to medical definitions, a cesarean section is considered as a second option, a procedure performed when, by some reason, the birth through the vagina cannot occur (Althabe *et al.* 2006, Shearer 1993). In Brazil however, this mode of birth has become so familiar that it is colloquially referred to as “just a surgery” (*simplesmente uma cirurgia*). ‘Just a surgery’ serves to illustrate the routine nature of cesarean sections in Brazil. Another nuance I draw from the quotation is the expression ‘seven layers of skin’ (*sete camadas de pele*), which also inspired the title of this thesis. I borrowed this expression from Joyce, whom I will introduce in the next chapter. Aside from using Joyce’s words to name this thesis, I appropriated her meaning. To my understanding, she is exposing that opening seven layers of skin cannot be consistent with a simple procedure. Discussing cesarean sections in Brazil is not a simple endeavor. It requires a nuanced reflection on the intricacy of this ‘common procedure’.

The expression ‘seven layers of skin’ stroke me as being fortunate both for its beauty and the purpose it serves to this discussion. This expression entails complexity. It connotes

the entangled social context of childbirth happening in a country where cesarean sections are so common and the rates so high. Yet, rates are not simply statistical numbers. They denote people with knowledge and emotions, that remember reflect and tell their experiences to one another. Cesarean sections are lived experiences that happen in Brazil more often than normal births. They are commonplace and part of everyday life, thus influencing how childbirth is experienced and practiced, precisely because often childbirth in Brazil is done through a surgical procedure. This thesis aims to explore the practices of childbirth in Brazil within a context of high cesarean section rates.

In order to honor Joyce and the women I interviewed, for inspiring me to explore the complexity of the experience of childbirth in Brazil by peeling off one by one the layers that compound this matter, I divided this thesis in seven chapters. The first chapter is this short introduction, where I make clear the division and structure of the thesis.

Chapter Two is concerned with the ways, techniques and strategies required to approach the complex field of childbirth. This research was carried out using a qualitative methodology, and data was collected by ethnographic methods. Throughout this chapter, I describe the methodological tools used to access the layers that shape the experience of childbirth in Brazil. The empirical data collected was filled with narratives I heard. Narrative theory, hence, will lay the foundation to the analyses. In Chapter Two, I also describe the methodological pathways followed in order to transform the empirical data into findings, and where narrative theory is used as the main tool to interpret the data.

In Chapter Three I begin to unfold the layers of childbirth experience in Brazil. This chapter describes the outside layer and is concerned with the place and the context where childbirth happens. I explore the elements that shape the social context of childbirth and the experiences of the women I interviewed, in which cesarean sections feature a main part. In addition, to clarify the circumstances surrounding the event of birth in Brazil, I describe the relevant literature discussing this issue. Historical aspects and social movements in Brazil are

also included in the discussion, as significant in framing the conditions in which birth is nowadays performed in the country.

The three following chapters are grounded in the analyses of three narratives told by women I interviewed. I have chosen three narratives I see as representative of childbirth practices in Brazil to explore the findings of this research. In Chapter Four I analyze a cesarean section that was scheduled, and that happened in a private hospital. This narrative serves as a basis from which I will foreground findings and discussions about birth as a medical event. In Chapter Five I discuss a home birth, performed by an advocate of natural births. I explore the main strategy developed by the Brazilian government and health sector as an answer to social pressures to reform the way childbirth is carried out in the country. This strategy, named ‘humanization of birth’ (*humanização do parto*), will be shown as having deep associations with what is termed in literature as the ‘natural childbirth movement’ (Cosslett 1994). Chapter Six is a description of a ‘normal birth’ (*parto normal*), experienced in a public hospital and from which findings that expose issues of social inequalities are explored. One by one, these chapters unveil the influences of a conceptual division between medical and natural events in producing regulations and policies to which women subject themselves in the birthing setting in Brazil.

At the end, in the final chapter, I summarize my findings problematizing the current political approach and public health policies towards childbirth in Brazil. The reasons why cesarean sections are high in Brazil have been widely discussed in the literature and proven undoubtedly multifactorial, in the sense that neither doctors, or women, nor health systems alone can be blamed (McCallum 2005). This study comes to fill a gap in the literature in Brazil about the moral and philosophical issues raised by the regulations in childbirth, implemented or claimed by government and society. Moreover, whilst this thesis concerns Brazil and birth in a Brazilian context, it contributes to understand gender issues, socioeconomic factors and policy changes in maternal health in the field of childbirth, that

may serve to explicate the same issues elsewhere.

To avoid confusion, I clarify below some terms I make use of in this thesis. I make use of the expression ‘vaginal birth’ or ‘vaginal delivery’ (*parto vaginal*) to refer to the exit of the baby from the mother’s body through the vagina. In some of the quotations however, this mode of birth is referred to as ‘normal birth’ or ‘normal delivery’ (*parto normal*), which is the main term used in Portuguese. The exit of the baby from the mother’s body through a surgical opening of the abdomen will be referred to as ‘cesarean section’ or ‘cesarean’ (*cesariana*) alone.

CHAPTER TWO: METHODOLOGY

So, birth... I think, you know that phrase we always hear, I don't know where it comes from, but I saw it in a Johnson's add, it says: "When a baby is born, a mother is born". I think that's it. That's what happened to me.

Patricia, who had a cesarean section in a private hospital

During my fieldwork in Brazil we borrowed a car. As I travelled with my then five months old child, and we were moving around with a pram, it was difficult to use public transportation. It was a very useful but quite simple car. No air conditioning, no hydraulic gear, and no radio. The city we stayed in, Curitiba, is a huge city and January is one of the hottest months. It was my first interview and despite leaving with sufficient time I was very anxious. It took much longer to get to the address than I had expected. Traffic was heavy and I am not the best driver. I got lost three times and it was very heavy to turn around my non-hydraulic geared red car. I finally got there with my sunglasses melting off my face because of the sweat. It was a very beautiful house: Two floors, red front door. I remember the freshness of the air when I got in. Ana, the woman I was going to interview, was alone with her baby, Matias. He was asleep in his room. We sat down around the kitchen counter and ate, while she told me about her pregnancy, her birth and breastfeeding experience. Ana conveyed to me all her memories from the last year into a story with a beginning, middle and end. What she experienced during one year, and recorded into memories, came out to me as a whole story, narrated in one hour.

Mattingly (2010) argues that when we narrate our experience in a story we organize events in a sequence, creating a whole that is governed by a plot. Events are included or excluded according to their relevance to the unity or how much they contribute to an ending, pursuing to provide to the listener a meaning to the story (Mattingly 2010). She explains: "This 'making a whole' is also making meaning such that we can ask what the point or thought or moral of the story is" (Mattingly 2010: 122). In her research she refuses to

constrain her analysis within the postmodernist claim of narratives as constructing the world that is being told, rather than referring to an existent world. The formal postmodernist claim is that all narrative forms are fictions, holding an “anti-mimetic” position in which narrative discourses distort the world they want to describe (Mattingly 2010: 121). Mattingly goes beyond this postmodernist argument, claiming that there is an underlying homology between “life in time” (2010: 122) and narrative structure. She relies on her discussions on contemporary phenomenological and hermeneutic philosophers that have argued that we experience life in order to provide a meaning or a moral to our life-stories, that the reality of our lived experiences has a narrative structure.

One of the philosophers Mattingly bases her analysis on, is Paul Ricoeur. Ricoeur discusses metaphors and narratives as belonging to the same phenomenon of semantic innovation, that is to say that both have an effect in producing meaning on the level of discourse (Ricoeur 1984: ix). Metaphors produce meaning by the displacement of words, reducing the logical distance between a word in its literal use and its odd use. In other words, meaning is created through the “work of synthesis” (Ricoeur 1984: ix), bringing together terms that at first seem distant then suddenly come close. By perceiving the similarity in our imagination, by figuring out the applicability of the word in its new function, we create meaning.

To Ricoeur, narratives produce meaning by translating chronological time into story time (Ricoeur 1984: 3). By means of the plot we re-structure our scattered temporal experiences. On the day of my interview, it took around three to four hours to go through the whole experience from leaving home, finding my way, hearing Ana’s story, eating, meeting her son, and coming back home. Yet, I translated this story in written words for the purpose of this chapter in a paragraph that can be read in less than a minute. When telling someone what we experienced, we also communicate the significance of the event to our lives.

Meaning in life can be delivered through narratives, by the work of synthesizing, or the inclusion of events that make sense in order to produce a meaningful story.

Throughout this thesis, Ricoeur's theory and Mattingly's application of his theory constitute the main tool to analyze the data I collected. However, a need for a theory to extract the meaning out of narratives came as a consequence of the quality of the data collected, rather than the opposite. These theories did not serve as a methodological device prior to and during fieldwork, but rather served as a framework to understand and frame the data analyses. This process of analyzing the material will be discussed in the following.

2.1 Early Purposes

Initially, my main interest was to address the increasing rates of cesarean sections in Brazil, in a quest for understanding the reasons behind this increase. In the process of writing a project proposal for this study, the literature review had not only provided me with an overview of the current knowledge about the rates of cesarean sections, which will be discussed in the next chapter, but had also disclosed the fact that many authors have attempted to answer the question: 'Why?' Still, the literature review has proven to be a great inspiration, encouraging me to shift my focus from the numbers of cesarean sections to the event of childbirth in itself. In the literature, I found the grounds to analyze birth as a relevant phenomenon and worthy of exploration. Alongside developing my research questions and objectives, a qualitative design emerged as an appropriate method to explore childbirth as a social phenomenon. As I came to believe after literature review that the cesarean section rates influenced the way childbirth was understood, I developed my main research question: To explore the *meaning* of childbirth in the Brazilian context of high cesarean section rates. When traveling to Brazil, I brought along a range of open-ended questions that would fulfill my objectives, a primary question being: Could you tell me about the birth of your child?

I was aware that this question would lead me to initiate my interviews with a birth story. However, I had underestimated the consequences of starting with birth stories. When starting my interviews with this question, I almost never had to ask much more. This question would initiate what seemed, at some point of my transcriptions, like endless stories from pregnancy ultrasounds to breastfeeding in the middle of the night, where the only thing I had to do was to nod. These stories included not only the event of birth itself, but also most of the issues I was interested in understanding. Often I used topics that had popped up during our conversations as ‘a hook’ for further exploration towards the end of the interview, as for instance: “You told me you decided for the cesarean section. How/why was that?” Even when I thought the woman had talked too little, as happened with some women with lower incomes that I interviewed, I would mainly use things mentioned by them to trigger the conversation.

The main consequence of proceeding this way was that my questionnaire guide was almost never used. My inexperience as an interviewer led to unexpected outcomes however: First, when I came back from fieldwork, the main bulk of my data was basically stories; second, my own strategy of using ‘hook-guided’ interviews caused me to forget to explore some initial issues that I had wanted to explore, that is if the woman I was talking to had not mentioned it on her own accord. During the process of analyzing my data material I bracketed significant expressions that would lead me to themes, categories and main findings. The data I had - mainly birth stories - demanded a theoretical framework that enabled narrative analysis. Mattingly (2010) and Ricoeur (1984) provided at this moment a useful entry point to explore the narratives. The collected stories were analyzed considering their narrative structure: When women I interviewed told me their stories, they synthesized their memories in a narrative. By doing so, they organized scattered events one after another to produce a whole, including or excluding events. I applied Ricoeur’s theory in order to explore the expressed meaning of the childbirth experience to the women I interviewed,

because the plot of their stories exposes the meaning of the childbirth event. With this perspective, bracketing became possible, because included events implied they were relevant to the plot of the story, and therefore to the meaning of the story.

2.2 The Women of this Study

For this study, I happened to interview only women. My main participants were women because I had chosen to collect narratives of experiences told by the person who gave birth, rather than her partner or family member. In addition I interviewed some professionals, but they all happened to be women. I stayed in Brazil for four months, from January to April 2014. While in Brazil I interviewed women that had experienced childbirth in the two main health sectors in Brazil: The public sector and the private sector. My aim was to isolate the descriptions of birth around these two settings, in order to acquire more congruent and manageable data. All women I interviewed, lived in Curitiba city. Curitiba is the capital of Paraná State, in South Brazil, being the eighth most populated city in the country, with almost 2 million inhabitants. I had chosen this city for practical reasons. I had lived there for ten years, when studying and working. This previous experience and knowledge of the city, was determinant for gaining access to the women I interviewed, both in relation the bureaucratic paths of ethical clearance or driving to the outskirts of this huge city.

One former colleague who works as a doctor in the city was an important contact person. Based on her suggestions, I interviewed Alice, Beatriz, Patrícia, Denise, Ana, Manuela and Meline¹. Except Alice, who gave birth in the public system, the others had their babies in the private system, and among those, only Beatriz had a vaginal delivery. Except Alice, these women were college educated and had middle or higher incomes. Beatriz worked as a teacher. Patrícia worked as an analyst in business. Denise was a social worker. Ana was a photographer and translator, and Manuela worked in a bank. Meline was social scientist,

¹ All names are anonymized.

but had stopped working to stay at home with her children. In contrast, Alice was from a lower income class and less educated, and worked as a maid. All of them were married.

After my interview with Denise, she also became a contact person. Through her, I got in contact with three other women: Katia, Carla and Paola. These three women had much lower incomes, and were also less educated. All of them had had vaginal births in the public sector, although Paola had a cesarean in her second pregnancy. Katia was married and a housewife. Carla worked as a cashier, and although she had lived in the past with the father of her child, she has never been married. Paola worked in a kitchen and lived with her partner, but she was also not married.

In addition I interviewed three other women through personal contacts. A friend of mine suggested Maria, and I contacted her through Facebook. She was married, worked as an engineer, and was the only woman I interviewed that had twins. She also had a cesarean section in the private system. Joyce was from my circle of acquaintances. I had met her a long time ago when I lived in Brazil, but we had lost contact for many years. I contacted her because I wanted to interview more women that had experienced vaginal births in the public system. Joyce was married and worked as a makeup artist in a beauty salon, and had a middle income.

Jessica was an active search. I had heard that some women were having home births in Curitiba, and I wanted to meet at least one of these women. A friend suggested her name, and I contacted her also through Facebook. Jessica had a home birth. She was a student, although she had quit her studies after her son was born. Most of my interviews happened in the women's houses, except Jessica and the nurse Carmen, whom I interviewed in a central shopping mall, and also the doula Tatiana who was interviewed at her work place. During our conversation, Jessica told me that she was assisted in childbirth by a group of obstetric nurses

that work with home births in the city, the Butterfly Group². The Butterfly Group is a private initiative of four obstetric nurses that conduct home births in Curitiba. Although the target of much debate among obstetricians and media, the group's work is well known and is formally registered with the local authorities. I found their website and sent e-mails explaining who I was and the purpose of my study, and Carmen agreed to being interviewed. She had been working for the group for nearly a year, was married and had no children of her own. On the Internet, I also found a group of doulas³. I also contacted some of them through e-mail, and Tatiana agreed to being interviewed. Tatiana worked as a doula and psychologist, lived with her partner and had one child. She was also a co-founder of an institute that promotes workshops about natural ways of conducting childbirth.

In addition, I also interviewed one obstetrician, Adriana. She was a resident some years ago when I underwent one-week internship in a maternity ward. I contacted her also through Facebook and interviewed her at her house. She was married, but had no children.

In sum, I carried out 16 interviews, in which seven women had cesarean sections and six had vaginal births. From the birth stories I heard, five took place in public hospitals, seven in private hospitals and one at home. The youngest woman I interviewed was 22 years old and the oldest, 41. Interviewing time varied from 30 minutes to two hours. Considering that transferability in qualitative analyses is a concept deeply connect to sampling (Malterud 2001), my adoption of purposeful sampling was made in order to promote diversity in characteristics of participants, and thus points of view. The limited number of participants was a choice to ensure that I would be able to thoroughly work with the data collected, but also provide enough time during data collection to establish for a good relationship with each of the participants. Diversity and contradictions in interpretive analyses are standard criteria

² Fictitious name.

³ Doulas are professionals that give emotional, physical and psychological support during pregnancy, birth and post-partum.

to be followed in order to enable quality data that provides meaning in the analyses process (Malterud 2001). All interviews were recorded with an electronic device and most of them were integrally transcribed. In addition, I had also one small notebook with field notes, a collection of digital news about childbirth in Brazil, and a pdf document of a printed booklet distributed by the Brazilian government to pregnant woman. I have also followed up blogs, websites and Facebook groups concerning childbirth in Brazil.

2.3 The Stories in the Study

When faced with so many stories, I had to endure the difficult task of deciding those I would deeply explore. Before traveling to Brazil I was aware of the discussions about birth and cesarean sections, topics often debated in media, academic and governmental circles. The elevated rates of cesarean sections in Brazil are usually taken as a reflection of the technological way in which birth has been approached, considered as too ‘medicalized’ (Page 2001, Serruya *et al.* 2004). The emergence of social movements against this development seems to reflect Brazilian society’s aspirations for a more comprehensive way of care (Page 2001). This comprehensive care has been materialized in Brazil through the notion of ‘humanization’ of birth (Carr and Riesco 2007, Page 2001, Serruya *et al.* 2004, Tornquist 2002). One of the objectives with this study has been to explore the dynamic between the notions of ‘medicalization’ (*medicalização*) and ‘humanization’ (*humanização*). The appropriation of these two concepts could potentially shape the way care is provided to pregnant and laboring women. Another objective of this research was to explore how the meaning of childbirth was related to actual childbirth practices.

2.3.1 Manuela: Themes Emerging

I decided to start analyzing one story that would represent a ‘medicalized’ birth. After having read through the literature concerning maternal health practices in Brazil, I chose to start with a cesarean section narrative. I decided to explore Manuela’s narrative. I selected Manuela’s

story for two reasons: a) She had a very clear and detailed account; and b) she was a first time mother that originally wanted a vaginal birth, but some medical reason pushed her to schedule a surgical birth. Manuela's story - being a white woman, highly educated, using the private system, wishing a vaginal birth in the beginning of the pregnancy that ended up with a cesarean section - is commonly found in the literature (Barbosa *et al.* 2003, Hopkins 2000, Potter *et al.* 2008, Victora *et al.* 2011). Similar to Manuela, Ana had also scheduled a cesarean section, but went into labor before the planed day. Patricia had a premature birth because of high blood pressure. Denise and Meline had had two cesarean sections, and their narratives jumped between the first and the second birth. Paola had a cesarean birth in the public sector and Maria had twins.

By analyzing Manuela's story with a Ricoeurian perspective, the presence and the place of events in the narrative was considered relevant to the meaning. These events highlighted various aspects of childbirth and maternal health. The themes that emerged from Manuela's narrative and that were explored are: 'design of the body' ('natural body' and 'medical body'), 'notions of normality' (normal or abnormal), 'boundaries of the maternal body' (opened and closed body), and 'knowledge/power' (medical knowledge and women's knowledge). These four themes were assembled under the category 'negotiations'. This term expresses the dynamics between the themes explored in Manuela's narrative.

2.3.2 Purpose shifted

The use of Ricoeur and Mattingly's narrative theories as analytical tools however, lead to unanticipated outcomes. In his theory, Ricoeur (1984) argues for an understanding of narratives beyond their use as stories of the past. He argues that the structure of 'life in time' is closely related to the structure of narratives, because both are in quest of a plot. He goes on to say that not only do we signify and give meaning to our narratives through a plot, we experience our life in order to "create sense out of situations" (Mattingly 2010: 123). He

argues that we organize our experience of time and that our decisions and actions are made to contribute to a desirable ending (Ricoeur 1984). Along this line of thoughts, Mattingly develops her study of actions as taken in a quest to give meaning, or to bring about a desirable ending (Mattingly 2010: 123). In the case of this study, this meant that the events in the narratives I was analyzing were at the same time: a) Included in the story because they were relevant to the meaning; and b) a reflection of decisions taken in the past *in order to* bring about a desirable meaning. Thus the events included in Manuela's story, I argue, were mentioned not only due to their relevance to the meaning of the narrative, but they *are* the cause of the story. As Mattingly puts it: "Stories need not provide complex psychological accounts of intentions but they do foreground the role of intending, purposeful agents in explaining why things have come about in a certain way. Stories are about *acts*" (Mattingly 2010: 130).

This presence of a purposeful action within the narratives represented a shift in my search for the 'meaning' of childbirth. The 'meaning' I wanted to explore before travelling to Brazil had a focus on the 'significance' of the childbirth event to women's lives. The narrative analysis however, brought out not only the 'significance' of the experience of childbirth but also the practical consequences of this event. What does it mean to give birth in Brazil? How do women experience childbirth in Brazil? What are the practices they undergo? What are their actions in relation to these practices? How does childbirth happen in reality? My shift of focus in searching the 'meaning' of childbirth from the 'significance' of this event to the women I interviewed to the 'consequences' in practical terms of having a baby in Brazil emerged when analyzing Manuela's story alongside the themes noted earlier (see p. 13). Her story is a description of her actions and reactions in relation to these themes, a description of her childbirth experience as a dialog between 'medicalized' and 'humanized' notions.

2.3.3 Jessica: Associations and Drawbacks

It was fairly easy to choose to discuss Jessica's story. It was the only home birth narrative I had and it had to be included. Although the notion of 'humanization' of childbirth in Brazil denotes a movement to modify childbirth practices inside the hospital, it has affected people's attitudes towards birth (Tornquist 2002). Jessica's story was at the same time an exception and the embodiment of the practices recommended under the notion of 'humanization'.

The difficulty with Jessica's narrative was the analysis. I interviewed Jessica twice. In the first interview I had some interference with the electronic device I was using to record it, and her narrative was captured in fragments. I only realized it after leaving the shopping mall where we met. I then contacted her again, asking if she would concede to meet me for another interview and she consented. For the analysis I had two narratives to use, one fragmented and one complete. Another issue to deal with was that Jessica's narratives were very long and therefore impossible to include as a whole, in the same way as I had proceeded with Manuela's narrative. In addition, opinions of other women I interviewed became relevant in the analyses.

Four additional themes became visible in Jessica's story, and were gathered under the category 'associations': 'alternative practices and nature', 'feminism and humanization', 'naturalization and humanization', 'pain and control over the childbirth event'. The word 'associations' describes the entangled relationship between the themes emerged from Jessica's narrative.

2.3.4 Alice: Practices and Frames

Manuela's story was chosen as representative of the birth that happens in the private system, while Jessica was chosen by being the only one from my interviews to feature more elements of a 'humanized' birth. Alice's narrative was chosen based on a need to describe a vaginal birth in the public system. I interviewed four women that experienced this kind of birth:

Paola, Carla, Joyce and Alice. I had met Paola and Carla through Denise. As Denise works as a social worker in a poor neighborhood in the outskirts of Curitiba, she arranged for me to meet Paola and Carla who lived in that area. We met in a community center, and although I had scheduled different times for each of them, they both came at the same time. They asked me if I could interview them together and I agreed. Their stories are intertwined. Joyce had a very clear account, but although she had given birth to her baby in the public system, she was from a higher income class than Alice. In Brazil, women giving birth in the public system generally tend to have lower incomes when compared to women giving birth in the private sector, who have middle to higher incomes (Barros *et al.* 1991, Béhague 2002). I have therefore chosen Alice's narrative as more representative of women that give birth in the public sector.

In the three narratives analyzed, I describe what childbirth means in terms of practices and realities experienced by the women I interviewed. With Alice's narrative, this purpose became more evident through the comparison of her story with practices advised by the Brazilian government in a booklet. The themes that emerged in Alice's narrative - 'evidences and moral values', 'evidences and practices' and 'social inequalities' - were grouped under the category 'frames'. The term 'frames' represent the discrepancies between 'theory' and practice described in Alice's narrative.

The three main categories - 'negotiations', 'associations' and 'frames' - reflect the main findings presented in this thesis that describe what childbirth in Brazil means in terms of the realities experienced by the women I talked to. These three categories represent a complex set of interdependencies - the notions women 'negotiate' and 'associate' - that shape and 'frame' the practices they subjugate themselves in their experience of childbirth.

2.4 The Interviewer

Considering *reflexivity* as one of the standard criteria for qualitative methods I recognize the relevance of my background as a doctor influencing my choice of the theme and methods, and shaping my work during fieldwork and the subsequent analyses (Malterud 2000). Rather than seeking to neutralize the effect of myself as the researcher, in the last part of this chapter I provide some reflections on my own role as a researcher.

I am Brazilian, my first language is Portuguese, and I am a woman and a mother. By doing research in Brazil, where the sociocultural environment is the one I am used to, I gave myself the challenge of stepping outside my own familiar setting, to be able to see the context with critical eyes. By choosing a topic that pertains primarily to women and women's health, being a mother and a woman myself provided easier access to the women interviewed in this study. However, although my entrance in the field of childbirth happen prior to my own pregnancy, I had to constantly question myself about the resonances of the fact that I also had experienced a cesarean section, and not a vaginal birth as intended.

I am not a philosopher or an anthropologist. Neither have I had any consistent training in the social sciences. I was trained as a medical doctor, with a residency in family practice. My lack of experience in the field of social sciences may have influenced and motivated my choice of literature and my curiosity towards a range of topics and theoretical understandings contributing to a rather eclectic choice of authors to frame my arguments in this thesis. My background as a medical doctor has influenced me to proceed more cautiously, especially when I interviewed women with lower incomes. The medical profession has a high status and is greatly valued in Brazil, influencing me to proceed with care and sensitivity in order to build trust and openness. I always introduced myself as a researcher from the University of Oslo doing a Masters in public health, as I did not see the need of presenting myself as a physician. If asked about my bachelor, I would then disclose my background. I felt that this

way of introducing myself helped to place the weight on my role as a researcher, rather than a medical doctor.

2.5 Ethical Issues

The project proposal for this study was sent to The Norwegian Regional Committee for Medical and Health Research Ethics (REK) and has received clearance from this institution. I have also sent a notification form to NSD (Norwegian Social Science Data Service). Before traveling to Brazil, I applied for ethical clearance from the Brazilian Committee for Medical and Health Research Ethics. However, the bureaucratic pathways followed in order to receive this clearance were proven frustrating and challenging. The whole process was delayed because a signature of a Brazilian authority was required for the application. As the study was planned to start in January, which comes to be summer vacations in Brazil, I had to wait for staff at the Brazilian university to come back from the holidays.

While waiting for clearance I had no authorization to recruit participants in official institutions such as hospitals or health units, as initially planned. I was advised however by my contact at the university in Brazil to start the interviews through personal arrangements. All women I interviewed during this time were informed that the study was still waiting for approval. This delay in receiving official clearance precluded the participant observation at health institutions that was initially planned in the proposal for the study. Approval was conceded towards the end of fieldwork by the Committee with no ethical hindrances or further requirements, except for a report by the end of the study. All women interviewed have signed an informed consent. I have furthermore anonymized all the participants in this study by giving them fictive names - of women, hospitals, groups, husbands, relatives and babies. Real names have not been stored electronically and all recorded sound files have been deleted after transcribing the interviews.

CHAPTER THREE: CHILDBIRTH IN THE BRAZILIAN CONTEXT

So, outside here, we're kind of a joke right? It's a joke what's happening in Brazil. I think it's a tragedy what's happening here.

Tatiana, doula

'Context' is a difficult word to define. Thus, it is wise to limit its meaning in this thesis:

When using 'context', I am referring to the surroundings influencing the way childbirth in Brazil is experienced. In this chapter I will discuss some of the surroundings that will lay the foundation for the discussions in the following chapters. The commonplace status of cesarean sections places this phenomenon as a relevant part of the context. I will begin this chapter describing the literature about the rates of cesarean sections in Brazil, studies that confirm a significantly high prevalence of surgical births in the country. In addition, I will discuss the impressions of the women I talked to about 'why cesarean section rates are so high in Brazil?' and I will compare their responses to the literature on this topic.

The rates of cesarean sections in Brazil are intimately connected with the way the health care system is organized in the country and the history of how this system came about. Therefore, after discussing the rates of cesarean section I will describe the division and historical aspects of the health care system in Brazil. This health care system has been shaped by political and economic happenings in the country in the last decades, which have also laid the grounds for the emergence of feminist movements in the country. I hence suggest that the creation of the health system and feminism in the country are intertwined, influencing how maternal health and childbirth have developed and been approached up to the present date. Following a description of the health care system in Brazil and its development, I will discuss feminist movements in the country.

By arguing that feminism and governmental policies in the field of childbirth have followed connected pathways, at the end of this chapter, I will explore the embracement of the notion of 'medicalization' by the feminist movement, a process that will reverberate in

the narratives that are analyzed in the following chapters.

3.1 Cesarean Sections

In the following chapters I will argue that cesarean sections are so commonplace in Brazil that they have become normal. It is normal because it is usual, typical or expected. The latest World Health Statistics 2014 published by the World Health Organization (WHO) states that 54% of all childbirths in Brazil are performed through cesarean sections (WHO 2014: 106). There are no higher percentages in any other countries.

The rise in cesarean sections is a worldwide trend, continuous for decades and Brazil. According to governmental statistics, in 2009, 43.8% of all births were cesarean births (Brazilian Ministry of Health 2009). Another WHO publication stated 45.9% in 2010 (Gibbons *et al.* 2010), and in 2011 The Lancet published a paper about maternal and child health in Brazil, featuring 47% (Victora *et al.* 2011).

In the literature I will discuss about cesarean sections in Brazil, it seems consensual that “too many” surgical births represent an issue that needs to be overcome. This matter is often based on WHO’s recommendation of a cesarean section upper limit of 15%. This percentage is commonly quoted and the rates of cesarean sections in Brazil are considered in the literature as “overuse of cesarean sections” (Gibbons *et al.* 2010: 3).

In 1985, WHO stated: “There is no justification for any region to have cesarean section rates higher than 10-15%” (Gibbons *et al.* 2010: 4). This statement is based on theoretical estimates, considering maternal and neonatal morbidity and mortality as the standard to measure effectiveness. The increase in number of cesarean sections is effective in reducing child and maternal mortality in countries where the former rates are below 10%, which is considered insufficient and fewer than necessary to the population at risk (Althabe *et al.* 2006). WHO revised its recommendations in a report from 2010, based on analysis of a worldwide range research. They concluded however, that current literature supports 15% as

upper limit (Gibbons *et al.* 2010), and based their conclusions on a survey on maternal and perinatal health in Latin America. This survey, carried out by Villar *et al.*, showed statistical association between rise in cesarean sections after 15%, with increased use of postpartum antibiotic treatment, greater fetal mortality and severe maternal morbidity and mortality (Villar *et al.* 2006). The researchers claims that the rise in surgical births does not improve pregnancy outcomes in developing countries, contradicting some data from high-income countries, which have shown no difference of perinatal mortality between low and high cesarean procedure rates (Li *et al.* 2003). Instead, the survey showed increased risk of preterm delivery and neonatal mortality (Villar *et al.* 2006). As the suitable rate of cesarean sections for each individual country remains debatable, WHO recommends between 15-20% as ‘adequate’ (Gibbons *et al.* 2010).

Another matter pointed out by WHO is that cesarean sections in absence of need represent a barrier to universal health coverage, since money spent on unnecessary surgical births could be invested by governments in different health care sectors (Gibbons *et al.* 2010). Cesarean sections in Brazil are far beyond the considered ‘adequate’ 20%, and the rising rates have long become a concern for the Ministry of Health. Some policies have been implemented. Since 1980 equal payment for all types of delivery was instituted (Béhague 2002, Victora *et al.* 2011). By 1998, the government started to reimburse surgical births to an upper limit of 40%, reducing to 30% in the year 2000 (Victora *et al.* 2011). In addition, the Ministry of Health launched the Pact for the Reduction of Cesarean Sections⁴ and the Program for Humanization of Prenatal and Childbirth Care (PHPN)⁵ (Serruya *et al.* 2004). All these measures had little or short-lasting impact on reducing the high numbers of surgical births (Béhague 2002, Hopkins 2000, Victora *et al.* 2011).

⁴ In Portuguese: Pacto para a Redução das Cesarianas

⁵ In Portuguese: Programa de Humanização no Pré-Natal e Nascimento

Brazil is one of the countries pursuing the Millennium Development Goal number 5 (MDG5), trying to reduce maternal deaths by tree-quarters by the year 2015, i.e. from 120 deaths of mothers per 100000 live births in 1990 to 30 deaths in 2015. The MDG 5 will not be achieved in Brazil, since the maternal mortality ratio (in 2013) remains by 69, far above the desirable 30 (WHO 2014)⁶. Since most maternal mortality can be prevented, the maternal mortality rate in Brazil is considered a severe violation of the reproductive rights of women (Cook and Bevilacqua 2004, Victora *et al.* 2011). Although many authors resort to the high maternal mortality rates in Brazil to advocate for the reduction of cesarean sections in the country, the extent of this association remains unclear (Victora *et al.* 2011). While the overuse of cesarean sections cannot be taken as a single responsible cause, and research conjectures about the significant role of illegal abortions in maternal deaths, the rise of surgical births symbolizes the vulnerability of the Brazilian health care system and its failure in implementing operative and effective policies. Along with illegal abortions, cesarean sections rates represent a major challenge for the country (Victora *et al.* 2011).

Most of the women I interviewed were aware that babies too often are born surgically in Brazil. . I decided to divide the opinions of the women I interviewed about why cesarean sections are so high in Brazil into three topical groups: *women*, *physicians* and *system*. I emphasize however that the opinions I will explore in this chapter do not reflect the reason why these women chose having a surgical or vaginal birth. Rather, I suggest they highlight the women's own views about what enables cesarean sections to be so common in Brazil. Making use of the issues exposed by the women I talked to, I will compare their opinions with the current literature.

⁶ The latest publication state 68,2/100000 live births (Leal et al. 2014a)

3.1.1 Women

It was pointed to me that it is very practical to know when the baby will come. Family can travel to assist the couple with the newborn baby and maternity leave and vacations can be planned. It is convenient. Fear was also mentioned as a strong issue. The women I interviewed mentioned that in Brazil people do not have a trustful picture of how the birth is going to happen. Therefore, decisions are often made on basis of what they have heard from others. Some women I interviewed mentioned that vaginal birth in Brazil is viewed as having two conflicting implications: a) It is the best for the baby's and the mother's health; and b) it is a risky and painful event. Women that deliver their babies through vaginal birth are considered courageous. Joyce, who planned and experienced a vaginal birth, explained that she was advised not mention to others her choice of birth mode, in order to avoid negative inputs. In her words:

It is so that when someone comes to me and says that they are pursuing the idea of normal delivery, you even get a bit scared; because those who want a normal delivery usually don't say anything not to get upset.

Manuela, who opted for a cesarean birth after having initially planed a vaginal birth, mentioned the feedbacks she had from others when revealing her intentions:

I really noticed the support to have a cesarean, if you think it that way. [When she said she wanted to have a vaginal birth, people would say:] "You are very brave!" That's how it was. I've noticed that people were afraid of the normal birth. It wasn't because the benefits of cesareans were better. No. (...) What I heard was that normal delivery was good and if you are going to do it you are very brave. Congrats!

The paradoxical popular discourse of vaginal birth as the best for mother and baby, but at the same time a risky and painful endeavor requiring strength and courage from the women that engage in it, seems to weigh the decision during pregnancy. It seems that popular opinions about pain and courage, combined with the convenience of knowing when the birth will

happen in the end persuaded women to decide for a surgical birth. This understanding, pointed out by my informants, is also described in the literature. Various researches suggest that, if asked, especially at the beginning of the pregnancy, women in Brazil answer that they prefer giving birth vaginally (Dias *et al.* 2008, Potter *et al.* 2008, Victora *et al.* 2011). Most of my informants, even the ones that did have surgeries, viewed vaginal births as preferable over cesarean births. At least for the first baby, most of them had originally planned, or considered, a vaginal birth. This seems to be a widespread tendency in Brazil. Vaginal delivery is said to be preferred, but cesarean sections are the outcomes (Dias *et al.* 2008, Potter *et al.* 2008, Victora *et al.* 2011). A questionnaire-based research in two private hospitals in Rio de Janeiro showed that out of 437 women, 70% wanted to give birth vaginally at the beginning of their pregnancies, yet only 10% ended up having a vaginal birth (Dias *et al.* 2008). Different research confirms what the women I interviewed had observed: That Brazilian women in general perceive vaginal delivery as risky and painful. In-depth interview studies with women has show that many women fear vaginal birth, and that it is perceived as a negative and risky experience, while cesareans are perceived as modern and safe and representing better quality care (Béhague *et al.* 2002, Melo e Souza 1994)⁷.

3.1.2 Physicians

The women I spoke to highlighted the influence of the doctor on women's decisions to have a cesarean section. Convenience was emphasized and some of the women I interviewed

⁷ Women's concerns about sexuality and body aesthetics is often cited as relevant in preferences for birth modes. Many articles exploring cesarean sections in Brazil have mentioned concerns among women and doctors about the maintenance of sexual functioning, as a reason to perform the surgery (*cf.* Diniz and Chacham 2004, Faúndes and Cecatti 1991, Melo e Souza 1994, Hopkins 2000). The Brazilian anthropologist Melo e Souza (1994) points out that the medical discourse has appropriated popular notions of body changes during pregnancy, and vaginal stretching during labor affecting sexual and urinary functions, to justify cesarean sections. The women I interviewed, however, did not mention these views when rationalizing their option for the surgery.

believed that it is practical for the doctor to schedule the birth. The doctors can plan their appointments and it is easier to combine work and family. Beatriz, who by the time I was in Brazil was expecting her second child and had had the first child vaginally, observed that there was always different reasons behind her friend's choices of having cesarean sections:

The thing is overdone! Even [hearing] from the experience of so many friends that wanted [a vaginal birth], who are healthy and it doesn't happen. I have at least three that are frustrated with that. Then they come to thirty-eight weeks and they [the doctors] don't want to wait. They say: "that happened [a reason is given to the woman], so let's, let's do it". They take the mother by surprise! Then comes the second: "You already have a scar on your uterus, so we have to do it". So, there is always an argument. It is a cultural thing.

Also, most of the women I interviewed mentioned that women in Brazil want to know who will perform the delivery. They want their personal doctor. They trust them. It was pointed to me that women in Brazil don't want to deliver with the on-duty doctor. They want to be with a person they know. In addition, they mentioned that vaginal births are time consuming. Many cesarean sections can be done within the time spent with only one vaginal delivery. This is an issue brought up by Patricia, who experienced a cesarean section. She said:

I think, specially now, what I have seen is that the doctors don't want to be available, because a normal delivery can last a whole day right? At least that's what I hear. (...) Because the doctors, if they are going to perform a normal birth they have to be available to the mother. They have to cancel all appointments to be available, and stay there waiting, maybe for ten, fifteen, twenty hours, to have the dilation and birth right?

A systematic review of publications related to women's request for cesarean sections has criticized the overestimation of women's role in the increase of cesarean births worldwide (Gamble *et al.* 2007). The authors argue that the scientific community has disregarded informed decision-making and quality of care as the basis for women's choices and requests related to birth modes. In many countries with high cesarean rates, women do not know about the real risks of cesareans and transvalue its benefits (Gamble *et al.* 2007: 332). Their

conclusion is that women's preferences should be approached through the lenses of quality of care and information provided to them, rebalancing the weight onto the role of doctors, nurses and midwives (Gamble *et al.* 2007). Hopkins conducted fieldwork in Brazil between 1995 and 1996 and according to her research doctors have the means to persuade women to choose a cesarean section, and as such playing an active role in increasing the surgery figures (Hopkins 2000). She condemns studies attesting that doctors decide for cesareans in order to respect women's autonomy, but disregard the imbalanced power relations (Hopkins 2000: 725).

McCallum (2005) however, has suggested that the responsibility for high cesarean sections in Brazil are not to be placed on the shoulders of specific social groups, namely women or doctors. In her research, she describes the social factors contributing to produce a context that sustains the common practice of surgical births (McCallum 2005). She also calls attention to the fact that placing the blame for high cesarean section rates on specific groups diverts the discussion about how to promote changes, claiming for a focus on the need for political will (McCallum 2005). In addition to negotiations between women and professionals as described by McCallum, physician's fears have also been described in the literature. In his commentaries to the scientific journal 'Birth', Klein reflects upon the influences of literature about the negative effects of the pelvic floor consequences of vaginal birth (2005). He describes studies from North America and Europe in which doctors, particularly female doctors, would indicate elective cesarean sections for their patients and themselves, underlining risk of pelvic damage as the main reason (Klein 2005). In Brazil, if doctors overvalue the risk of vaginal birth, and if convenience is relevant to them, as mentioned by the women I interviewed, likely a surgical option would seem suitable.

3.1.3 The System

In order to discuss about the Brazilian health care system, the last topic pointed out by the women I talked to as influencing the rates of cesarean sections in the country, it suffices here to mention that the Brazilian system encompasses both public and private care. All women I interviewed mentioned differences between having a baby in the public and having a baby in the private sector. The main observation made by them was that in the public sector there is no choice. I was told that women are forced to have vaginal births in public hospitals and that cesareans are only performed as a last resource. Some also mentioned that in private hospitals no protocols are followed. It is the woman and her doctor deciding. If women are paying they are entailed to choose. This issue came up in my interview with Denise. Denise has two daughters, both born by cesarean sections. She said:

(...) With SUS⁸, you don't have choice right? My sister in law went to have at SUS. She was in labor, I don't know, for around twenty hours? The baby came out with the clavicle... [Broken] They really force you. It doesn't matter. But I think it's because of the health plans. I don't know if there is a protocol. I can't understand because everyone you talk had a different [experience]. That's why I think there is no protocol [standard] for this. Maybe for the doctors it's easier like this, scheduled [to schedule a cesarean birth]. (...) I think it has to do with the fact that you are paying, it is in the plan [health insurance], and it is included. At the end it is a choice between the patient and the doctor there.

Brazil is internationally reputed to be a country of immense socio-economic imbalances. The socio-economic disparities are also reflected in the rates of cesarean sections in the Brazilian health system. An overall of 80% of all births happen surgically in the private system, in contrast to 35% in the public (Brazilian Ministry of Health 2009). The variance between the two systems exhales inequality. If I consider the perceptions of the women I interviewed that Brazilian women fear childbirth and if I recognize this fear also among physicians, I cannot do less than argue that women do not have the same level of autonomy when giving birth in a

⁸ SUS - Sistema Único de Saúde (in Portuguese) - It is an abbreviation of the name of the public health care system. Translated means Unified Health System.

public hospital. Nor do doctors. Given the assets private hospitals have, one may infer that, the treatment is not equal either. Nevertheless, the number of cesarean sections in the public setting is still noticeable high. But in order to translate into written words how the influences of health care system distribution in unequal treatment affects childbirth, I will explain under the next section how, and in which basis, it is organized.

3.2 Health Care System in Brazil

The health care system in Brazil is a public-private blend of service providers and purchasers, and it is formed by three sub-sectors, distinct but intertwined: public, privately contracted and private health insurance (Paim *et al.* 2011: 1785)⁹.

The public sub-sector is officially called the Unified Health System (Sistema Único de Saúde) and is financed by the government at federal, state and municipal levels (Paim *et al.* 2011). Brazilians call it SUS. The two other sub-sectors cover the privately contracted sub-sector, financed by public and private funds, and the private health insurance sub-sector, formed by health plans¹⁰ and insurance companies (Buss and Gadelha 1996, Paim *et al.* 2011). The privately contracted sub-sector is sometimes financed by public funds because a range of health services the government offers to the population under no charge are purchased from private companies. Most hospitals and diagnostic clinics are private. Nearly 70% of all hospitals in Brazil are private. In these buildings, 38.7% of beds are available to SUS through contracts (Buss and Gadelha 1996, Paim *et al.* 2011).

Some women I interviewed gave birth in private hospitals that provide services for the government. Therefore the care received was free of charge for these women, and this is viewed as receiving care through SUS. In order to avoid confusion along this thesis, I will use the expression ‘public system’ when the woman did not pay for her health care, and

⁹ See also Bahia 1999, Buss and Gadelha 1996, Cordeiro 2001

¹⁰ A Health Plan is an institution that provides health care to plan members for a fixed monthly payment.

‘private system’ when the costs were covered by her, either through a health plan or direct payment. The public system is used by 70% to 80% of the population (Buss and Gadelha 1996, Diniz and Chacham 2004), meaning that this percentage of the population have access to health care free of charge, while only 20% to 30% of the population pays for health assistance.

Correlating health care divisions in Brazil and childbirth, it was pointed to me that for having a baby in Brazil there are three options. In popular words: “Pay private”, “have health plan”, or “have the baby at SUS”¹¹. To “pay private”, means direct out-of-pocket payments. This is a very pricy option. The majority of the population cannot afford it and to do it is very uncommon (Buss and Gadelha 1996). To “have health plan”, means that the woman, through her work or as a free choice, has paid for private health care insurance or health plan. Most of middle-high income women prefer and have this option. At last, if none of the above is possible, the women will “have it at SUS”. Most of the low-income population is left with this option.

3.2.1 History of SUS

The creation of SUS as the main health care provider is the result of the political and economic scenario in Brazil in the last century. In the mid-1970’s, when the former health system - National Social Security Health Care Institute¹² (INAMPS) - was created, the political context was one of huge instability, a rebound of military takeovers and dictatorship (Escorel 1998, Paim *et al.* 2011). Liberalization was in process and the economy was in decline (Escorel 1998). INAMPS was responsible for providing financial resources to health care by this manner: Employees charged workers on their payrolls for social security and retirement pensions; the government received this payments from employees, and paid

¹¹ In Portuguese: “Pagar particular, ter plano de saúde ou ter o bebê no SUS”.

¹² In Portuguese: Instituto Nacional de Assistência Médica e Previdência Social

private institutions for the health care provided to workers (Luz 1991, Paim *et al.* 2011). Thus, federal subsidies were mainly designated to private health care institutions (Luz 1991, Paim *et al.* 2011). The system was centralized, bureaucratic and underfunded (Luz 1991, Paim *et al.* 2011). Coverage was fragmented and unequal, available only for those that had formal work. Care was delivered in accordance with work categories. Better job, better coverage. The private sector became strong (Luz 1991). Inflation and economic recession worsened in the beginning of the 1980's, and social security dropped into a crisis (Escorel 1998, Luz 1991). A reform was nourished, and civil society rather than government or international agencies drove the creation of SUS (Paim *et al.* 2011: 1778).

A health reform movement called the 'Sanitary Movement' (*Reforma Sanitária*), driven by trade unions and grassroots sectors allied with health professionals and left-wing parties, dates back to the 1960's in Brazil, but it was consolidated during the democratization process during the 80's. This movement was the source for the Brazilian legislation on health provision: Health as a universal citizen's right and as a duty of the State (Buss and Gadelha 1996, Luz 1991). This is presently the ruling legislation since the last Brazilian constitution was implemented in 1988, after the end of the military dictatorship (Paim *et al.* 2011). Inspired by holistic ideologies, defined in the Alma Ata Declaration (1978) and spread through welfare reforms around the world, embracing social and political aspects beyond biology in defining health, civil society fueled the changes in system (Buss and Gadelha 1996, Paim *et al.* 2011). In theory, SUS became responsible for providing health care to all citizens. Yet, the implementation of the new public system was a long process in the following years after the constitution in 1988, a period also marked by neoliberal governmental measures and strong oppositions from the private sector (Bahia 1999, Cordeiro 2001, Luz 1991, Paim *et al.* 2011). Thus nowadays, besides the right to use the public system, all citizens are also free to pay for private health insurance (Bahia 1999). That is, if they can afford it.

3.2.2 Cesarean Sections and Health Care System

A study collecting data from end of the 1970's and beginning of the 80's, when INAMPS was active, explores the numbers of cesarean sections in hospitals in Rio de Janeiro and São Paulo (Janowitz *et al.* 1982). They divided participants in three categories: Private, insured (those covered by INAMPS) and indigent (Janowitz *et al.* 1982). Surgical births were significantly higher among private patients, followed by insured patients, with indigent women having the least number of cesareans (Janowitz *et al.* 1982). The study suggests that this contrast cannot be explained only by differences in medical indication for the surgery (Janowitz *et al.* 1982). As a matter of fact, if only medical reasons were considered, by logic, women from lower income groups would present more risk factors for cesareans (Barros *et al.* 1991, Béhague 2002). The authors concluded that economic grounds influenced doctor's decisions to perform cesarean section more often in private or insured patients (Janowitz *et al.* 1982).

Janowitz's study shows that cesarean sections were rising and more common among higher income groups, already by the end of the 1970's (1982). Janowitz's and another study by Barros *et al.* (1991) suggest that before SUS was established, surgical births were performed mainly on wealthy women, and poor women were not entitled to a cesarean section by the simple fact they could not afford it (Barros *et al.* 1991, Janowitz *et al.* 1982). If the principles of SUS are considered, it infers that nowadays all women have the same right to have a cesarean section and that the government is compelled to pay. Today however, the surgery remains rising and more frequent in higher socioeconomic groups, exemplified by the rate differences between public and private sectors (Béhague 2002, Kilsztajn *et al.* 2007, Victora *et al.* 2011). Is there any difference between before and after the implementation of SUS? My own findings suggest that there is a difference. In the past, cesarean sections were likely to convey status because only wealthy women could afford it. Currently, status is acquired by means of choice beyond wealth (Béhague 2002, Hopkins 2000, Melo e Souza

1994). Joyce told me:

The government, it doesn't stimulate normal birth in the private sector. Also, because that would be stupid, they want money right? But in relation to the Unified Health System of Brazil, the SUS, they want the highest amount possible of normal births. So they hold on, force... force normal birth until the end. They only do a cesarean in the last case, the last, last possible. When the mother or already had had, for example, two other cesareans, then she can't have a normal birth. Or when the mother has a severe health problem, or when the child is at risk... So I think that's the kind of stimulus the government gives [in the public sector]. I think, in my opinion, it's kind of a big stimulus that the government gives. If us, poor wretches that depend on SUS could choose, the majority would be cesareans too. Because if so-and-so that lives in the favela¹³, everything she wanted when she is pregnant is to have money to have a cesarean and not to have to do a normal birth. She doesn't do the normal birth because she wants. For real, what she wanted is to be able to do a cesarean, but she does not, because she doesn't have the means...

Women in Brazil are not only paying for their surgical births, they are paying for their right of having a cesarean section as an option. The surgery is now accessible to poor women through SUS, but it remains as a mark of wealth. The implementation of the new health care system translated the depth of Brazilian social inequalities through the shift from absence of access to inability to choose.

3.3 Women's Autonomy

The right of self-government, as a state or condition of freedom of one's action or decision is what I will signify when using the term 'autonomy'. When talking about a cesarean section, the surgery may be performed with a medical indication or without it, also called elective (Morrison and Mackenzie 2003). An indication for a cesarean may occur during the labor process, as an emergency, or during prenatal care, due to previous disease of the mother contraindicating a vaginal birth (Penna and Arulkumaran 2003). Seen through the lenses of 'autonomy', the surgery is divided in two: As a doctor's opinion or a patient's demand.

¹³ Favela is a Brazilian shantytown or slum.

Maternal mortality is considered higher after cesarean sections, when comparing with women after vaginal births (Villar *et al.* 2006, Kilsztajn *et al.* 2007). Nevertheless, it is argued that this mortality is expected, since most of cesarean sections are performed because of some complication, meaning that the higher mortality is associated with complication, rather than the procedure in itself (Morrison and Mackenzie 2003). Thus, there is no clear agreement in the literature on risks comparing vaginal births and elective cesareans, that is, if the patient have not had a complication, it is not performed as an emergency, or associated with risk factors (Morrison and Mackenzie 2003, Penna and Arulkumaran 2003). Morrison and Mackenzie through a literature review of recent articles comparing risks of both birth modes, state no evidence of greater mortality risk of elective procedures in relation to vaginal deliveries (2003). The authors discuss statistical literature about other risks to take into consideration when deciding the suitable birth mode, such as: Impact on the perineum, psychological effects, subsequent pregnancies and fetal well-being. Although the data collected by them derived from studies carried out in high-income countries, they conclude that there is no evidence that vaginal delivery is safer than an elective cesarean and argue for a favoring women's 'autonomy' as decision makers (Morrison and Mackenzie 2003).

Some authors have criticized this approach, because it provides women's 'autonomy' as grounds for scheduling a cesarean section (Hopkins 2000, McCourt *et al.* 2007, Melo e Souza 1994, Potter *et al.* 2008). It has been underlined that a surgical birth has dimensions beyond the medical arena, and that in Brazil the preference for surgical births among women and doctors is culturally influenced by ideas of beneficence and women's 'autonomy' (Melo e Souza 1994). McCourt and colleagues, also through a literature review, defend that under surgeries performed, very few women requested the procedure (2007). When they did, it was associated with fear of birth or doubts concerning quality of care (Mccourt et al. 2007). Following the same line as Hopkins (2000), Potter and colleagues also criticize the discourse about women's 'autonomy' (2008). Through their data they argue that most of elective

cesareans performed under request were from women that expressed preference for vaginal birth at the beginning of their pregnancies (Potter *et al.* 2008). They suggest that doctors have power and means to persuade women to request a cesarean, thus women's decision at the end turns out in no decision at all (Potter *et al.* 2008: 38). Ethical issues become apparent. Is it correct to perform a surgical birth when there is no need? Is it ethical to compel a woman to have a vaginal delivery when she understands that she doesn't want to? Women's autonomy in the literature about childbirth is still being debated. It remains uncertain if women in Brazil have the right to choose, and if they do, if their decision is informed or induced.

3.3.1 The Feminist Movement in Brazil

The fact the women's autonomy is regarded in the debate about the rates of cesarean sections is an effect of historical happenings in Brazil. As happened in many other countries, feminist ideologies played an important role in women's attempt for recognition in Brazil. Brazilian feminists, when describing how the movement happened in the country, call it "women's movements" (*Movimentos de Mulheres*) (Soares 1998: 34). They allege that this name is more appropriate to describe the unique and singular characteristics of the Brazilian feminism (Soares 1998).

In the beginning of the 20th century, Brazil witnessed a "first wave" (Alvarez 1990: 10) of feminist movements, mainly formed by upper class women, in a quest for vote rights and access to education. However, it was only during the military government that this movement gained ascendance, boosted by the economical recession produced in this political period, and the country saw the rise of a "second wave" of feminism (Alvarez 1990: 10). In contrast to the 'first wave' that emerged within elite groups, this second moment in the history of the movement was marked by the engagement of middle to lower class women (Alvarez 1990). The feminist movement in Brazil happened as an echo of the Brazilian socio-political setting, born of the engagement of different women's groups in opposition to an authoritarian

government (Alvarez 1990, Sarti 1988, Soares 1995).

Rapid industrialization and urbanization has taken place in Brazil during the 20th century (Paim *et al.* 2011). The main cities quickly grew overpopulated, and lacking in infrastructure. From 1930 Brazil was under an authoritarian government, called ‘the Vargas Dictatorship’ (*Dictadura Vargas*) after the name of the president during that period, Getúlio Vargas (Paim *et al.* 2011). A series of populist governments followed after Vargas’ suicide in 1945 that ended his dictatorship, yet the liberalism and democratic instability in the years that followed lead the country to a military takeover in 1964 (Paim *et al.* 2011). By the end of the 1970’s however, the militaries started a slow process of political transition and liberalization towards democratization, which happened only in 1985 (Paim *et al.* 2011).

In order to contextualize health care within this political scenario, I recall the before mentioned: The former health care system INAMPS was created in 1977, during the military rule, and the new constitution was proclaimed only in 1988, given legal bases to the present system, SUS. This glimpse of democratization in the 70’s, together with a series of economical crises, fomented civil organization against the army in that period (Alvarez 1990, Sarti 1988, Soares 1995). According to Alvarez (1990) during the 1970’s and 1980’s, hundreds of women’s groups “emerged in the periphery of major cities and over four hundred self-professed feminist organizations were formed” (Alvarez 1990: 10).

The feminist movement in Brazil happened through an articulation between high, middle and low-income groups in a “circular movement of mutual influence” (Sarti 1988: 40, my translation). Women from low income groups were the first to openly protest against the government, described by Alvarez (1990: 50) as “militant motherhood”, due to the amount of mothers gathered in these manifestations, claiming concrete welfare goods such as day care centers, electricity, asphalt and sewage systems (Alvarez 1990). According to Alvarez (1990), it was motherhood and not citizenship, and the lack of urban infrastructure and general decline in living conditions, which provided the main referential to engage women in

urban social movements (Alvarez 1990: 50). Whilst the political setting during the dictatorship did not allow a feminist movement struggling for ideologies and identity, as happened in North America and Europe in the 1960's, it enabled women's entrance into the political arena in Brazil (Alvarez 1990).

As noted earlier, the dictatorship came to an end in Brazil in 1985, finishing the longest military-authoritarian regimen endured in Latin America (Alvarez 1990, Paim *et al.* 2011). The women's movement however, continued to remain engaged in the Brazilian politics. Democracy granted space for a more 'feminist' discourse in the political agenda. Women affiliated to the newly established political parties personify the role of a 'feminist', bringing up to debate women's issues (Soares 1995). Gender inequalities, women's health, reproductive rights and violence became central matters. The women's movement in Brazil has, however, taken on a new shape: Independent from the State through NGO's, yet with governmental representation, feminists now hold ruling and administrative positions (Alvarez 1990, Costa 2009, Sarti 1988, Soares 1995). By the end of the 1980's and throughout the 90's, a National Women's Rights Council¹⁴ was established, and is still working as an alliance between the government and the movement, providing resources and insights in finding joint solutions on women's matters (Costa 2009).

3.3.2 Gender, Sex and Body

The gender theorist and philosopher Judith Butler argues that 'women' is the subject of feminism (1990). She points that throughout history, feminist theory has assumed that there is a common identity under the subject 'women' in need for political representation (*ibid.*: 1). She explains however, that this representation of 'women' along politics ends up producing 'women' as gendered subject for whom political representation is pursued (*ibid.*: 1). This representation, form, define and reproduce the subjects, in order to meet the criterion of the

¹⁴ In Portuguese: Conselho Nacional dos Direitos da Mulher

system (*ibid.*: 2). According to Butler, feminism embraces and represents an identity of ‘women’ that feminism itself has discursively defined (*ibid.*: 16). Feminism produces its own subject by means of representation before law, designing women’s identity as a unified gendered category (*ibid.*: 2-3).

Apart from influencing the construction of a unified category of women, feminism has discursively introduced the binary division between ‘gender’ and ‘sex’ (Butler 1990, Longhurst 2005, McDowel 1999). Within feminist theory, ‘sex’ has been understood as the biological inheritance, the genes, the anatomy and the hormones (Nelson 2009, Squire 2009). ‘Gender’, on the other hand, has been seen as socially and culturally constructed through relations of power (Nelson 2009, Squire 2009). This traditional approach was important for feminist theory in order to maintain a representation, because in this view, gender is not determined by sex alone, thus challenging assumptions of biological determinism (McDowel 1999, Squire 2009). Recent research however, argues that ‘sex’ is equally socially constructed (Butler 1990: 10). A feminine sex cannot exist without a body, and a body does not exist outside a social context (Butler 1990, Longhurst 2005, McDowel 1999). The context in turn, constructs how the body is understood and experienced (Longhurst 2005). This logic challenges the split between sex and gender, lodging both categories within the ‘body’ (Longhurst 2005, McDowel 1999).

The use of the term ‘body’ and its derivatives has become progressively more used in social science research in the last twenty years (Longhurst 2005). It seems that the very own paradoxical nature of the body, as symbolic, cultural and social, as well as material and real, has roused the interest to explore it (Longhurst 2005). Everyone *has* and *is* a body (McDowell 1999: 40). All bodies exist in a place, and at the same time, is a place (McDowell 1999: 40). In this thesis I have chosen to refuse the division between ‘sex’ and ‘gender’, approaching childbirth neither as a ‘gender’ matter, nor as a ‘biological’ event alone, but rather as an event that is experienced by the body, which is both socio-cultural and real.

In addition, I make use of the reasoning that bodies are understood and experienced in a place (McDowell 1999). I therefore argue that the way childbirth was experienced by the women I interviewed is influenced by the Brazilian context and historically shaped by feminist movements, dictatorship and healthcare reforms. Moreover, I make use of this perception of the body as *existing* in a place and as well *being* a place to understand women and their bodies within a context, and subsequently being the place where childbirth is performed.

The influences of feminism in the way childbirth is carried out in the country will be shown further on in this thesis when I discuss governmental policies and health care programs towards pregnant and laboring women. In addition, this issue will be also further on approached in the discussion about the representation and production of a view of women's body as 'medicalized'.

3.4 Medicalization

3.4.1 Childbirth from Home to Hospital: Historical Aspects

In Brazil, nearly 98% of all births happening today are performed in hospitals (Brazilian Ministry of Health 2009). In addition, most childbirths in Brazil are assisted by medical doctors, and midwives are scarce (Carr and Riesco 2007). This condition, I suggest, is the result of philosophical changes and political movements in the world that have come to influence Brazil in the last two centuries.

Brazil was a Portuguese colony until the 19th century, which have contributed to a European influence on local obstetrics. Changes in obstetric care in Europe, and by consequence also in Brazil, was influenced by changes in medical knowledge and perspectives in western societies, dating as far back as The Enlightenment Era. Philosophers of the Enlightenment emphasized reason and scientific method as the means whereby society would be reformed, disregarding faith and tradition. This new rational way of thinking spread throughout Europe and United States until the end of the 18th-century, affecting politics, economics and culture. This ideology provided the grounds for the humanistic democracy

that steer most of current western societies and Brazil is not an exception in this respect. It influenced childbirth inasmuch as midwifery care symbolized the old traditional way, while medicine emerged as the new modern method (Kukla 2005). The American philosopher Rebecca Kukla argues that while notions of organic functioning of women's body has always permeated our imaginary, the Enlightenment thinking intensified understandings that settled women's body within a maternal body with a maternal role (Kukla 2005: 218). This maternal role, justified by women's organic reproductive functioning, becomes of relevance as a nation building appliance, since the mother - as well as her body - provides the vehicle through which a citizen comes into being (Kukla 2005: 218).

Until the 19th century, as in many other parts of the world, childbirth in Brazil happened at home, assisted by midwives (Vieira 1999). The midwives were local experienced women with an empirical knowledge, rather than formal training (Brenes 1991). Midwifery in Brazil has never been consolidated throughout history as an autonomous profession due to conservationist political pressure that overvalued medical training that reflected European tendencies (Brenes 2008). Instead, during periods when midwifery training existed in the country, it was always under the regulation of the medical or nursery profession. This tradition has perpetuated itself until today and midwifery in the country is a now degree achieved after nursery school, rather than independent training (Brenes 1991, Carr and Riesco 2007).

Obstetric teaching within medical training however, was established in Brazil since 1808 (Brenes 1991). The history of medical schools in the country is filled with struggles for resources and investment, overemphasizing theory and lacking structure for practice (Brenes 1991, Vieira 1999). Until 1875, when the first maternity ward was built, physicians graduated without having seen one single labor or examined a pregnant woman (Brenes 1991, Vieira 1999). Even after the implementation of the maternity, practice for obstetric training remained scarce, as women were resistant to hospitalization and male examination (Brenes

1991). Female students have been allowed into medical teaching since 1832 but the first female doctor in Brazil graduated only first in 1887 (Brenes 1991). As such, medicine remained a male-dominated field until the 20th century.

Feminist scholars in Brazil argue that institutionalization of childbirth in Brazil happened as a consequence of a need for practice by male students, allied with a medical discourse of denigration of lay midwifery (Brenes 1991, Vieira 1999). According to them, childbirth became the first practice through which medical profession consensually obtains access to women's body (Brenes 1991, Vieira 1999). The notions of women's body as a nation-building appliance, and views of obstetricians as the expertise on the care of these bodies, laid the foundation to Brazilian hospital -and medical centered childbirth care today.

3.4.2 Reproductive Rights: from a Nation Concern to Women's Rights

The postwar period brought new concerns to the whole world and these concerns reverberated in the current political scenario in Brazil. The debate concerning women's reproduction became an issue in Brazil as in most western societies. During the Vargas Dictatorship, identified with Nazi-fascist ideologies in Europe (Paim *et al.* 2011), public health became a huge concern for the State, as a healthy population equaled wealth by means of available labor force (Vieira 1999, Paim *et al.* 2011). The postwar period in Europe, concurrent in Brazil with an unstable democracy in between the Vargas Dictatorship and the military takeover, marked western societies with a concern about overpopulation in developing countries (Costa 2009). A cluster of poor people would be more susceptible to communist ideologies and riots (*ibid.*). High fertility rates in Brazil, as well as in other Latin-American countries, are taken as accountable for poverty, high child mortality and poor health conditions (Vieira 1999). Pregnancy outcomes and reproductive matters become therefore a key issue to be approached by the State.

During the 1960's, following the line from the beginning of the century, when public health was part of the nation's strategies, allied with international pressure for fertility policies, the Ministry of Health started to suggest natality control measures (Costa 2009). However, this governmental initiative was incisively opposed by civil society, influenced by social movements and left wing parties, claiming that reproductive freedom was important to reassure the nation's sovereignty, refraining from North-American imperialism (*ibid.*). This absence of agreement between the government and civil society provided grounds for the foundation of nonprofit institutions in the country, financed by United States' birth control programs and the United Nations Population Fund (UNFPA) (*ibid.*). These nonprofit institutions carried sterilizations and free distribution of contraceptive pills of questionable quality and disregarded of additional health care, which was heavily criticized by feminist organizations (*ibid.*).

Infant and maternal health were addressed together by the government until the 1970's, when feminist voices started to challenge this view on mother and child as a single category, by foregrounding topics that concerned only women and were of interest purely to women (Vieira 1999). Birth control also found its place in this debate, and contraception was no longer discussed as a nation's right but as women's right, and central to their autonomy (Costa 2009).

In 1983, the Integral Assistance to Women's Health Program (PAISM)¹⁵ was created in order to ensure a more complete health care towards women. PAISM remains active nowadays, but its effectiveness in promoting informed decisions concerning reproductive choices have been criticized (Berquó 1993, Costa 2009, Vieira 1999). Fertility rates have been dropping since the 1970's, to 1.8 children per women in 2006 (Brazilian Ministry of Health 2009). However, female sterilization persist as the main contraceptive method, and as

¹⁵ In Portuguese: Programa de Assistência Integral à Saúde da Mulher

such contradicting the program's purpose of offering alternatives to birth control and reassuring women's autonomy with no loss for their reproductive capacity (Berquó 1993, Costa 2009).

3.4.3 *Medicalization and Feminism*

Feminist scholars in Brazil argue that the woman's body has gradually become a medical domain, claiming that it is women's reproductive functions that have enabled this process (Brenes 1991, Brenes 2008, Vieira 1999). It is common to find in the literature descriptions of women's bodies as 'medicalized' (*cf.* Vieira 1999). As discussed above, at first, medical discourse discouraging home deliveries assisted by midwives and medical access to new techniques and technologies, supported by high infant and maternal mortality, brought childbirth to the hospital. Second, women's bodies are understood as the producers of the nation's population in need for care and control of the state, and medical views legitimate women as naturally intended for motherhood.

The medicalization critique has been central to socio-anthropological literature about health (Lupton 1997). The term 'medicalization' was first used in the 1970's by the American sociologists Irvin Zola (1972) and Eliot Freidson (1970) to call attention to the increasing range of power and influence of medicine as profession, applied to ever more private and social aspects of daily life (Lupton 1997, Smeenk and ten Have 2003). This critique argues that medical discourse has been gradually incorporated into popular vocabulary, and human existence is understood in medical terms, as 'health' is assimilated as normal behavior and 'sickness' or 'illness' as deviant behavior (Smeenk and ten Have 2003). The main author quoted by feminists in Brazil along with Zola, is Ivan Illich (1975) who claims that medicine, as it is practiced in current Western societies, has weakened people's health through iatrogenic and side effects, along with extenuating people's ability to look after their own health (Lupton 1997: 95). Feminist theory has embraced the 'medicalization' critique when

condemning definitions of women's organic functioning in terms of disease, and medical views of women's reproductive capabilities by legitimizing their role as mothers.

Concerning childbirth, feminist literature has also criticized understandings of childbirth in terms of risk, requiring hospital management, technologies and medical surveillance (Henley-Einion 2009). This view is by some scholars said to be influenced by the Enlightenment thinking, when the body is first understood as a machine that manufacture a product, vulnerable to injuries and requiring constant check-ups (Smeenk and ten Have 2003: 154). Childbirth then is viewed as a risky process, demanding technology and controlling, in which the main concern is the outcome (Henley-Einion 2009, Smeenk and ten Have 2003). Following Illich's claims, feminist literature argues that women in Western societies have lost trust in their own body's ability to give birth, relying on technologies and medical knowledge or expertise (Henley-Einion 2009). In addition, articles related to 'medicalization' of childbirth, emphasize the power granted to medicine through their knowledge that is consensually accepted as dominant, promoting imbalance of autonomy between professionals and laboring women (Henley-Einion 2009, Jordan 1997, Lupton 1997).

Feminism in Brazil has had a strong impact on the way maternal health is conducted in the country. The critical view of childbirth as 'medicalized' has influenced governmental programs and actions aiming towards a 'de-medicalization' of this event. This process has enabled some advances in the care for pregnant and laboring women in the country, at the same time as it has created some drawbacks. In the following chapters the repercussions of this process and of the notion of childbirth as 'medicalized' will become apparent through the issues unfolded in the narratives I will discuss, and in the literature I will compare the stories with. In addition, in the discussion about the narratives I will suggest a further approach, which goes beyond a 'medicalization' notion of childbirth in Brazil and that allows a wider perspective to explain the complexity of this phenomenon in the country.

CHAPTER FOUR: THE CESAREAN SECTION NARRATIVE - A MEDICALIZED NORMAL BIRTH METAPHOR

It was not about those stupid things like pain. It was not about that. It was about the baby and I being fine. Because I was scared: “We’ve been through a lot until now [the birth]. And if something happens at the end, because of pride of not wanting to do a cesarean?” Everybody speaks against it [cesarean]. But we ended up deciding for it and it was really good.

Meline, who had two cesarean sections in the private system

In the previous chapter I have argued that feminist scholars often portray childbirth as ‘medicalized’. According to these scholars women’s organic functions have come to be viewed by society as in need for control and surveillance, because any deviation is interpreted as risky, requiring medical intervention (Vieira 1999: 73). Thus, childbirth in Brazil happens predominantly in the hospital setting and is assisted mainly by physicians, who have at reach a large scope of technologies. The high rates of cesarean sections are considered in the literature as the pinnacle of the ‘medicalized’ Brazilian system of birth, perhaps influencing maternal mortality and therefore urging governmental actions and policies (Carr and Riesco 2007, Misago *et al.* 2001).

Along the following pages I will explore Manuela’s birth story. As noted before, I have selected Manuela because her story provides a typical example of middle high-income Brazilian women that give birth within a private setting. During her pregnancy she endorsed both delivery modes - cesarean or vaginal - but had a slight preference for a normal birth. By the end of her pregnancy, an alteration on the ultrasound motivated a decision for a cesarean section, which was performed a week later.

In this chapter, Manuela’s story and the themes that emerged from it are used as a means to foreground issues of power. Rather than endorsing previous research that supports an orthodox medicalization critique, the analyses presented in this chapter corroborates an understanding of medical power as producing and constraining the experience of childbirth. I argue that the themes in Manuela’s story, while suitable for valid interpretation in light of a

‘medicalization’ critique, cannot be restricted by it. I will argue for an approach that considers medical knowledge and practices as the medium in which childbirth is understood and experienced. In addition, as introduced in the previous chapter, I will focus on the woman’s body as the place where childbirth is experienced, exploring how the power of medicine tailors women’s experiences of their bodies’ phenomena.

4.1 Beginning: a New Being Inside the Body

I interviewed Manuela in her son’s room. After setting up the device to record the interview, I asked her to tell me everything she could remember from her pregnancy and childbirth. She then told me that she would follow a chronological order and start from the pregnancy:

I didn’t expect to get pregnant in May, even though I was not protecting myself. We were not using any contraceptive method. It was very nice when we discovered, because it was in a moment of changes, in my work. Suddenly I was going to be a mother, and I was going to take vacations. So, it was a bit scary because I didn’t know if I would be okay or not. But it was a good moment because the changes in my work contributed to a smooth pregnancy because I went to work in a much less stressful environment. I worked only six, seven hours a day in a place that was only computer work. (...) So it was a smooth pregnancy with very little stress at my work. I had time to get home and rest. That was really good and it was what I did. Especially in those first months, when we have those uncomfortable heartburns. I had a lot of heartburns during the first months. I used to come from work, sit down on the couch and Roberto helped [with house chores] if I was too uncomfortable. But it was a very smooth pregnancy. I enjoyed it a lot. Every ultrasound was really cool! It was almost unbelievable that there was a child growing inside. It was wonderful and very weird at the same time. Having another being, from a preexistent being.

Many things changed. For example, we used to go to bed very late and already during the pregnancy, when it was nine in the evening, I couldn’t take it anymore and would go to sleep. But I had many happy people around me, sharing the joy of the pregnancy. (...) There was many people, friends and family, supporting me. So the pregnancy was really cool. During the pregnancy, Roberto was with me at all appointments, all ultrasounds. Having Roberto to participate in everything since the beginning was really nice. He could feel closer, more like a father. Not only to me, the mother, but closer to the child. (...)

4.1.1 Medical Body

Manuela said she would start her childbirth story following a chronological order. She chose to start her narrative stating that she was not expecting the pregnancy to happen “in May”,

suggesting that the pregnancy was expected despite happening at an unexpected time. The anthropologist Mattingly (2010) makes a distinction between the structure of chronological time and narrative time. Chronological time is structured with one event followed by the next one successively in a linear mode. In the narrative this linear structure is transformed in a whole story, organized by a beginning, middle and an end (Mattingly 2010: 124). At another moment in her narrative, Manuela had mentioned that she discovered her pregnancy in June. Since before ‘discovering’ the pregnancy Manuela did not know she was pregnant, the chronological order of the events Manuela experienced started in June. However, in her narrative structure the beginning of the succession of events that structure her childbirth story started with the conception “in May”.

The historian Barbara Duden (1991), in her analyses of body perceptions in the 18th century claims that the modern body as we understand it today originated as a consequence of medical examination. In her study of how the body was experienced in a German village on the 18th century, Duden challenges contemporary views of the body in which an assumption of a real and natural corporeality is taken for granted (Duden 1991: 3). She argues that the Enlightenment thinking - when observation and description of the body acquired a state of scientific method - has consolidated the assumption that exists an ahistorical ‘real’ body provided with ‘natural’ phenomena ready to be ‘discovered’ by medicine (Duden 1991: 5-6). In her view, dissection, examinations of the external and internal body, and anatomical descriptions have become the source that defines the reality of the body as it is presently experienced¹⁶. Our ‘real’ body is a product of medical description, because it became commonplace that anatomical descriptions “truly grasped and reproduced reality” (Duden 1991: 4). Today’s private bodies are, according to Duden (1991: 4), products of medical description, and can be only experienced within this notion.

¹⁶ In her book, Duden makes reference to the reality of the body as how it is experienced today by Western societies.

Manuela described the beginning of her childbirth story through the lenses of a medical understanding of how reproduction is and how it can be controlled. Through the narrative structure it is possible to infer that despite discovering the pregnancy in June, Manuela experienced a pregnancy that started inside her body in May.

4.1.2 Body in Medical Charts

Manuela described her pregnancy as “smooth” (*tranquilo*)¹⁷. ‘Smooth’ seems to describe the course of the pregnancy Manuela experienced with no complications or conditions beyond the expected, kept within the borders of what is understood by her as a regular or normal pregnancy.

Following a similar line of thoughts as Duden, the philosopher Rebecca Kukla (2005) explores the care pregnant women and newly mothers receive today, as a consequence of major philosophical shifts during the Enlightenment Era. Similar to Duden, Kukla also argues that medicine provides the standards for experiencing the body, and that this is an understanding of the body that emerged during the Enlightenment. Kukla (2005: 127) holds that western societies have developed a notion that pregnancy ought to be ‘designed’, presuming that fetal outcome can be perfected and that any ‘risk’ that may hinder perfection should be avoided. In pursuing perfection, pregnant women and new mothers are taken as responsible for self-surveillance, practicing a proper and conscious pregnancy or motherhood. In addition, a pregnancy is perceived as ‘normal’ when it falls within a quantificational ‘expected’. We define what is ‘expected’ to happen during pregnancy by assessing and comparing each pregnant body with a set of population statistic measures. According to (Kukla 2005: 131), this perception goes beyond defining women’s choices, “it also provides women with a self-understanding that individuates them via their statistical

¹⁷ ‘*Tranquilo*’ has more than twenty translations to English being also translated as ‘tranquil’, ‘peaceful’, ‘quite’ or ‘calm’. Manuela also used the same word in many other moments of her story, and it was also used for most of the women I spoke to. It expresses an event without any deviation from the expected.

position with respect to populations”. Each pregnant woman experiences her own pregnancy by positioning herself in relation to risk and population statistics.

The beginning of Manuela’s birth narrative is a pregnancy experienced as starting in her body before it was conscious, and featured by the absence of any deviation of the established normalcy. Manuela experienced her pregnancy as ‘smooth’ and ‘normal’ because she did not experience events outside the borders of a statistically predefined ‘normal’ pregnancy. Manuela’s understanding of her own pregnancy was thus shaped by positioning herself in relation to a generic population of pregnant women. Manuela spoke of the heartburns she experienced in the beginning of her pregnancy using the pronoun “we”, which includes pregnant women at large, implying a perception of heartburns as expected during pregnancy. The website Baby Center Brazil, the first one on Google’s list when searching for ‘heartburns in pregnancy’, starts with the following outline: “Main point - heartburns are common and harmless during pregnancy, but very uncomfortable” (Baby Center Brazil 2015, my translation). This statement exemplifies my argument that pregnant women are motivated to read their particular experience in terms of their position in relation to population statistics. The pregnant woman is presented with heartburns as ‘common’ and ‘harmless’, motivating her to place herself within the generic group of pregnant women, outside the danger curve. In addition, “very uncomfortable” provides the frame in which her body perception can be read, and it is the word Manuela used to describe herself in this state.

Kukla argues: “Women are encouraged to understand their particular pregnancies in terms of where they fall on various statistical curves for risks and to design their pregnancy regimes around the goal of minimizing their position on these curves” (2005: 131). According to her, pregnant women are accounted for changing their life in order to achieve a minimal risk and excellence of pregnancy outcome (*ibid.*: 126). The changes Manuela described in her narrative are tailored by her responsibility in designing a public and socially accepted normal pregnancy. She described the changes at her work to a less stressful setting

as bringing a smooth, normal pregnancy. It seems that she interprets ‘stress’ as capable of affecting her body and the fetus. The pregnancy Manuela experienced was shaped by her responsibility of practicing a conscious and proper pregnancy. By avoiding stress, working less, resting more, sleeping earlier, Manuela was able to establish a pregnancy regime that was responsible and accepted as proper. Had Manuela not experienced any events beyond the ‘expected’, if she had not read about pregnancy, not subjected herself to prenatal care, examinations and tests, nor had fulfilled her body’s need for rest – in other words, if her practices of self-regulation were not proper – her pregnancy would not be understood as ‘smooth’ or ‘normal’. Expected changes in pregnancy ‘happen’ because changing behavior seems to be the public and socially accepted practice of a proper pregnancy.

4.1.3 Fetus Outside the Body

Manuela highlighted that the pregnancy was an enjoyable experience. One element of the pregnancy regime Manuela designed that seems to have contributed to a pleasant experience was the ultrasound. In Manuela’s narrative the ultrasounds are described as producing two effects: a) Seeing the child growing inside; and b) bringing Roberto closer to the child.

Duden (1993) calls attention to the permeable way women experience their pregnant bodies. The ultrasound is one of the technologies that contribute to a ‘transparency’ of women’s skin by transforming the womb into a public space (Duden 1993, Kukla 2005). Manuela spoke of ultrasounds as a way of bringing her and Roberto “closer to the child”. According to Ricoeur, the rhetoric of the metaphor takes the unit of reference of a word and by the displacement of the word, and resemblance with a new meaning produces semantic innovation (Ricoeur 1977: 3). The unit of reference for bringing something or someone ‘closer’ is the act of shortening the distance in space or time. In the narrative of Manuela the word ‘closer’ is displaced of its reference since neither Manuela nor Roberto can physically shorten the distance with the fetus in space or in time. The resemblance is observed by the

meaning that is produced by Manuela's expression. Manuela used the expression in terms of intimacy and bonding with the fetus, in terms of two people becoming close friends or being a close relative.

The metaphor Manuela used, however, expresses the 'reality' she experienced. Duden (1991) argues that it is relevant to recognize perceptions as capable of defining reality. In other words, Manuela's perception of her own body defines the 'reality' she experienced. Manuela's perception of the ultrasound as enabling her bonding with the fetus is a metaphor in a rhetorical sense, but the same time it figures the 'reality' experienced by Manuela.

According to Kukla (2005: 73), before the Enlightenment, representations of fetuses were very rare, and when existent, they were very schematic and abstract. During the middle of the 18th century, due to the advancement of anatomical techniques, the representation of the fetus inside the women's bodies changed drastically, and these representations became very detailed (Kukla 2005: 76). However, it was the use of technologies in our contemporary time that placed the inside of pregnant women, the womb, outside their bodies, visually accessible as a public space (Kukla 2005: 111). Manuela spoke of "a being" from a "preexistent being". The "being" she mentioned was "growing inside" was displaced and made visually available outside the "preexistent being". Recognizing that all ultrasound images are very similar, Duden (1993) claims that ultrasound pictures have invited women to build an image of a generic fetus and understand it as the 'being' growing inside their bodies. In this perspective women experience their insides as visually accessible outside their bodies, and are encouraged to build a bond with the content of their displaced womb. The image of the content is a generic figure of a fetus, which can be understood and experienced as 'their' fetus (Kukla 2005: 109). Through the ultrasound Manuela is brought "closer" by forging a relationship to the image that by being identical to a generic figure of a fetus is understood within the borders of a normal pregnancy.

According to Kukla and Duden, it was also during the Enlightenment that the fetus first acquired a state of 'being', with an identity separated off from the woman's body. The perception of the fetus as a public entity outside the mother's body however, as a 'being from a preexistent being', is produced by our present technology and understandings of the body. The 'displacement' of the fetus outside the mother's body produced the distance that was perceived by Manuela as in need of being made 'closer'. Manuela perceived the 'displacement' of the fetus outside her body as placing the fetus 'closer' to the father. As a figure of speech, Manuela's words define a metaphor as Ricoeur (1977) speaks of, because in a linguistic sense neither Manuela nor Roberto can get any 'closer' to their child. However, the 'resemblance' of the image of her fetus with an image of a generic fetus enables the perception that the image is the 'being' growing inside her body.

Ricoeur (1977) goes even further in his analyses of the metaphor, making a transition from semantic innovation to hermeneutic innovation, claiming that metaphor as discourse has the power to refer to a reality outside of language (Ricoeur 1977: 6). Ricoeur's claim endorses Duden's (1991) argument that perception and imagination produce the reality that the body experiences. Since Manuela's visual understanding of a fetus inside goes as far as a picture of a generic fetus, the image that is seen on the screen is the same 'being' that grows inside. Even before she could feel the baby, she was presented with an image of her real baby, enabling an experience of the baby as a separate being outside her body, publicly available. 'Seeing the baby' becomes a critical moment for the establishment of a 'closer' relationship with that individualized fetus (Kukla 2005: 113), contributing for the design of a normal pregnancy.

4.2 Middle: Finding a Way to Exit the Baby

So far in the narrative, Manuela had told me how she experienced her pregnancy. She could have proceeded to the next moment when she gives birth. Instead, Manuela chose to describe

the events that led her to decide for a surgical birth. She continued:

During the pregnancy we were always open to both, a cesarean or a normal birth. The doctor too. She said that she accepted the normal birth, if done with anesthesia. (...) So, I would have the anesthesia at that moment, after you are in labor, after I don't know how many centimeters, they give the anesthesia so the baby comes out by normal birth. But it wasn't normal [birth] because by 38 weeks I had an ultrasound that showed fluid reduction [amniotic fluid]. Then I had two more ultrasounds, one every three days, and there was not enough fluid. Then she [the doctor] told me that we could wait... I was almost 39 weeks... that we could wait if we wanted him to come out by normal birth. But I could have some complications because of this fluid reduction, and we would have to go for a cesarean. So, she asked what we wanted. (...) She said: "You choose." Then I said: "Well, if it is better for the baby, if we have the risk of... in the middle of the labor... I am there in the middle of a labor, and I end up having to go for a cesarean section, having, let's say, two births!" So I said: "No. I don't mind having a cesarean. (...) So we scheduled. (...) Then she opened her agenda and said: "We have all these days, I'm calling the hospital. Which day is good for you?" So it was something scheduled. We didn't wait for the labor.

Manuela related that during the pregnancy, until the event she was about to tell me, she and her husband were "open" to two delivery modes: A cesarean section or a vaginal birth, meaning that Manuela and Roberto would endorse any of the two mentioned birth modes. Her doctor, Manuela explained to me, would "accept" the vaginal birth "if" carried with anesthesia, implying that her doctor would not comply with a vaginal birth without anesthesia.

By the end of the interview, I asked Manuela if despite being 'open' to both modes, she had any preference. She answered me that during pregnancy she preferred a normal birth because a cesarean section in her perception is an "artificial way of taking the child out". I also questioned her about how she felt her doctor was in relation to any preference. Manuela answered me that she perceived her doctor as preferring the cesarean section, and the reason would be that, according to Manuela, cesarean sections were easier to plan and to fit in her doctor's busy schedule. Manuela also told me that Roberto was supportive of her decision for the cesarean section.

4.2.1 A Medicalization Perspective

Some authors have discussed the active role of doctors in inducing Brazilian women to decide for a surgical birth. Hopkins (2000: 725) states: “Doctors clearly have more decision-making power in the hospital birthing situation, and their medical expertise and authority is often marshaled to convince a woman to “choose” a cesarean”. Potter and colleagues (2008: 33) conclude in their paper: “Many cesarean sections were scheduled for an “unjustified” medical reason, especially among women who, during pregnancy, had declared a preference for a vaginal delivery.”

Manuela’s story illustrates to some extent what is claimed by Hopkins and Potter. It can be interpreted that Manuela’s doctor employed the ultrasound feature inducing Manuela’s decision for the cesarean section. Manuela’s story, despite not exemplifying a “hospital birthing situation” as explored by Hopkins (2000: 725), demonstrates her claim. If one applies Hopkins’ (2000: 725) perspective, Manuela’s doctor actively used her medical “expertise and authority”, asserting the fluid reduction with an idea of risk and complication. In this view Manuela can be seen as having had very little choice, if no choice at all, to decide for a vaginal birth. If Potter and colleague's account of “appropriated justification for cesarean delivery” (Potter et al. 2008: 36) which included narrow pelvis, chronicle fetal distress, breech presentation, twins or previous cesarean is considered, Manuela’s surgical birth can be interpreted as ‘unjustified’. Also, Manuela’s portrayal of her doctor as “accepting” a vaginal birth option, describes her doctor as an arbitrary figure, allowing and authorizing Manuela to have her baby coming out of her body under the condition of anesthesia.

The literature presented above is consistent with a medicalization critique because this view often represents medical staff as actively making use of their authority and power (Lupton 1997: 100). If Manuela’s story is analyzed with this perspective a possible interpretation is that her choice was tailored by her doctor’s influence in deciding for a highly

‘medicalized’ birth. This approach places Manuela’s doctor as the main actor influencing the decision, leaving Manuela unable to take an effective action, and choose freely on her own.

I suggest however, that the medicalization perspective has limitations and drawbacks. Deborah Lupton argues that one of the major hindrances of the medicalization critique is the overemphasized asymmetry of the relationship between medical staff and patients (Lupton 1997: 97). She argues that literature that endorses a notion of ‘medicalized’ phenomena often describes medical professionals as actively seeking to maintain their authority, and often places patients as having “little opportunity to challenge their doctor’s decisions... seen as helpless, passive and disempowered” (Lupton 1997: 97), which at first seems clear in Manuela’s story if a medicalization perspective is adopted. According to Lupton, a ‘medicalized’ interpretation is quite often advocated in feminist literature, endorsing a notion of medicine “as a largely patriarchal institution” and women’s will “crushed beneath the might of medical profession” (Lupton 1997: 97). Manuela’s story, if analyzed with a medicalization perspective may portray Manuela’s doctor as actively inducing the decision for the cesarean section, and Manuela as unable to perceive the coercion, naively believing that the decision was hers. In the rest of this chapter I will provide an analyses of Manuela’s story that demonstrates that critical interpretations through the lenses of the ‘medicalization’ notion fail in recognize the complexities of power relations in the birth setting.

4.2.2 Beyond Medicalization: Negotiations and Power Relations

Kukla (2005) reflects upon the dichotomization between the concepts of ‘passivity’ and ‘activity’, ‘objectification’ and ‘autonomy’, ‘natural’ and ‘medical’, often described in feminist literature on pregnancy and childbirth (2005: 135). She draws attention to some difficulties with such an approach, arguing that the relationship between “personal choice, personal responsibility, public accountability, subjection to authority, self-discipline and knowledge” is a complex one (Kukla 2005: 134). She argues that a black-and-white portrayal

is problematic and may oversimplify negotiations and interdependencies between women and the care provided to them when pregnant or giving birth (Kukla 2005).

Lupton (1997) claims that it is possible to go further in the analyses of medical knowledge, practices and the relationship generated through the encounter of medical staff and patients. According to her, Michel Foucault's (1994) conceptualization of power may bring relevant insights in understanding power relations and authority in this setting (Lupton 1997). Although a Foucauldian perspective endorses the orthodox medicalization critique to some extent, mainly by acknowledging the enormous influence of medical understandings in shaping human existence, it departs from the usual approach "contending that there is no such a thing as an authentic human body that exists outside medical discourse and practice" (Lupton 1997: 99). In a Foucauldian perspective women's understandings of their body and experiences are not separated from medical understandings because according to his view, all bodies are experienced through the medical production of the body. This approach leaves no space for an interpretation of authority as simply negatively and oppressive. Rather it understands power and authority as productive and forming knowledge - of medical professionals and women - and producing their discourse (Lupton 1997: 98).

Foucault's main contribution to theory in social sciences is the understanding of power and knowledge as the producer of the modern body and its surveillance (Turner 1997). Foucault described knowledge as deeply interconnected to power, arguing that "any extension of power involved an increase of knowledge and every elaboration of knowledge involved an increase in power" (Turner 1997: xiii). This is not to say that knowledge and power are the same, but rather to see them as mutually dependent. In the same manner that, in a Foucauldian perspective, the body cannot be experienced outside medical understandings, knowledge is intrinsically related to power.

In political opposition to Marxism and existentialism that understood power on a macro-level, as a "unitary and centralized construct primarily repressive in character" (Fox

1997: 35) or as a possession of particular social groups, Foucault describes power as a relationship diffused throughout all social groups and all levels with a productive feature (Turner 1997, Lupton 1997). Foucault saw power as a relational strategy that happens to exist through disciplinary practices, meaning that individuals voluntarily subjugate their daily activities or practices to surveillance. Medicine exercises power through a process of active seeing and perception of the body by medicine, which emerged in Foucault's texts as the 'clinical gaze' (Foucault 1994: 122). The 'clinical gaze' operates through "observation, examination, measurement and the comparison of individuals against an established norm" (Lupton 1997: 99). The gathered information creates a discourse that have "effects of truth" (Fox 1997: 35), explaining and providing solutions to individual's everyday life activities (Turner 1997). Within a Foucauldian perspective, the body is the target of power, and medicine - as well as other institutions as law and religion - produces, regulates and represents bodies through this disciplinary surveillance (Turner 1997: xv). Later in his work, the body was turned into the self, and Foucault explored not only the body as produced and constrained by the power of medicine, but as a more active notion of individual's subjectivities and identities as products of resistance to power (Fox 1997). In making use of a foucauldian perspective, medicine not only provides the framework in which Manuela understands her body and experiences her pregnancy, but also exercise a moral authority giving the moral standards that enables her to decide for a socially accepted proper birth mode.

4.2.3 An Open Body

Again, I make use of Ricoeur's (1977) claims about the ability of metaphorical utterance in producing a reality that cannot be described by language. While 'open' describes Manuela as not finally settled during the pregnancy with one of the two birth modes she mentioned, still this word as a metaphor expresses Manuela's experience of a permeable and 'open' body,

easily accessible by medicine. Manuela's 'openness' to the cesarean section, I contend, demonstrates the power of medicine, as Foucault understands it. The reduction of amniotic fluid is a new element that had to be negotiated by Manuela. If Manuela had not been 'open' to a cesarean section, she would refuse this option by maybe questioning why the fluid reduction represents risk, or by searching for a doctor more enthusiastic towards vaginal birth. By describing herself as 'open', Manuela exposed her body as easily penetrable and accessible, as a non-closed space that voluntarily allows access to the baby. Manuela's 'openness' unfolded her sense of responsibility to subject herself to cut her body open in order to ensure the outcome of her pregnancy. Her subjection was socially accepted as a conscious and safe choice by Roberto and by her doctor, friends and family. The entanglement between Manuela's 'openness' to the cesarean section, her responsibility with the outcome of her pregnancy, and the shaping of a publicly accepted birth mode, demonstrates the power of medicine as a complex relationship, producing as well as constraining Manuela's decision.

In analyzing Manuela's decision for a cesarean birth, the reduction of amniotic fluid represented possible complications during labor. However, it appears that Manuela's concern was not the possible final complication, that is, the cesarean section, given that this option became her first choice. Rather, her main concern was about not having to undergo "two births". At a closer look, the fluid reduction triggers the possibility of having to experience "two births", something that motivates her decision for a cesarean section.

The unit of reference of the word 'birth' is the emergence of the baby from its mother's body, the point in time when the baby starts a life as a physically independent being. Manuela's baby could come out of her body through a preexistent opening, the vagina, or through a manufactured opening in her belly, the cesarean section. If it is physically impossible for the same woman with only one baby, to have this baby coming out through her vagina *and* through a cut on her abdomen at the same time, it is physically impossible for

Manuela to have ‘two births’ from her pregnancy with Leo. Manuela creates a new meaning to the word ‘birth’ by perceiving the applicability of the term in a new function, creating a metaphor in a Ricoeurian sense (Ricoeur 1977: ix). It appears that the “two births” Manuela was referring to are: a) The cesarean section; and b) the labor. It seems that Manuela did not chose the cesarean section because she is concerned in experiencing one birth ‘or’ the other; cesarean section ‘or’ labor. Rather, by choosing the cesarean section in the first place, Manuela avoids the combination - two births - of a labor that ends with a cesarean section. In other words, Manuela’s cesarean section happens in order to avoid labor in combination with expelling the baby through a manufactured opening.

4.2.4 A Normal Birth

Medicine provides the frame to define what a ‘normal’ birth is. The ‘normal’ birth Manuela understood and was willing to experience, comprehended labor with expelling the baby through a preexistent opening. Manuela spoke of the “risk” of experiencing ‘two births’. The possibility of experiencing labor without achieving the exit of the baby through the vagina represented exposure to danger or harm. Turner (1997) argues that in a Foucauldian perspective, medicine produces individual ‘problems’, explains and provides the solution for them, and by this manner medicine exercises a form of moral authority (Turner 1997: xiv). The ‘problem’ produced in Manuela’s story is the possibility of undergoing a labor that cannot end with the baby coming out through the vagina, which is explained by medicine and internalized by Manuela as dangerous. The ‘solution’ that medicine provides is to manufacture an opening. The power of medicine as a moral authority abides in the notion that in pregnancy and childbirth any risk should be avoided, and that it is the mother’s duty to subject herself to any measure in order to ensure fetal outcome. By scheduling the cesarean section Manuela can fulfill her responsibility with a rational notion of safety along the process. Medicine provides the principles for right and wrong behavior that produces and

constrains Manuela's decision as a proper and conscious choice of birth mode.

As mentioned before, Mattingly, in her narrative analysis, argues that one event after another becomes one event because of another, and that in narrative logic, one event becomes the cause of later events (Mattingly 2010: 129). By the point Manuela decides for the cesarean section, a "sense of an ending" starts to take shape (Mattingly 2010: 128). A quest to 'normalize' her experience seems to govern the plot of Manuela's story. In order to avoid "two births", which seems to represent danger, Manuela chose to schedule a cesarean section. I do not by any means intend to argue that I believe Manuela understood her cesarean section as a vaginal birth. It seems clear to me that for Manuela a vaginal birth comprises the exit of the baby through the vagina. However, I want to show that the childbirth Manuela experienced, in character, was normal. The normality of Manuela's experience is grounded on the expected following of events of her choice of birth mode. By the end of her interview, when evaluating her experience and the differences between 'normal' births and cesarean sections, Manuela stated:

The baby didn't have any complications. He went through a surgical procedure, but everything went accordingly, it happened within expectations, with child and mother well. We didn't have complications. It's the normal of the cesarean right? Thinking about normal... the normal of the cesarean. The mother goes to the hospital and she gets admitted... I thought mine was like that... following step by step. (...) Everything was just right.

David Armstrong (1995), making use of Foucault's description of self-surveillance, argues that the development of western medicine have blurred the clear distinction between health and illness. In his view, in western societies any individual is a potential patient, in need for surveillance (Armstrong 1995). Furthermore, the power of medicine can be observed in the extension of this notion to individuals, producing the experience of the body in terms of possible disease, in need for self-care and self-discipline. Information about population health status is gathered, producing knowledge and discourses that have "effects of truth, which are

neither true or false” (Fox 1997: 35), but provide individuals with the guidelines for behavior. In a Foucauldian perspective, this process of production of knowledge and discourses is independent of human agency (*ibid.*: 36).

Following the same line of thoughts, de Swaan (1990) exemplifies this self-discipline that follows medical discourse with an effect of truth, observing the shifting practice of physical activity, from pleasure, experience or character formation to a notion of practice “for the sake of heart and lungs” (de Swaan 1990: 59). Armstrong describes this development as a “problematization of the normal” (Armstrong 1995: 395), acknowledging Foucault’s argument about the power of medicine in producing the notion of ‘normal’ or ‘abnormal’ and the consequential idea of every ‘normal’ as a ‘potential abnormal’.

The notion of ‘normality’ in western societies is a referential view, where ‘the normal’ is produced through comparison of each individual with population statistics (Armstrong 1995). The uniqueness of each individual can only be read from a composition that summarizes features of general population (Armstrong 1995: 396). I have argued before that this phenomenon is salient in producing women’s understandings of their individual pregnancies. During pregnancy women are encouraged to define the uniqueness of their individual pregnancies, understanding their experiences as normal or abnormal, by their place in relation to population statistics (Kukla 2005). Furthermore, they are encouraged to self-discipline, subjecting themselves to surveillance in prenatal care for instance, in order to keep their pregnancies within normality borders (Kukla 2005). Why then, when childbirth comes would they proceed in an unlike manner?

Among middle-high income women that give birth in private hospitals in Brazil, which is the group Manuela identified herself with, cesarean section rates are as high as 70% to 90% (Carr and Riesco 2007, Potter et al. 2008). I cannot affirm that Manuela knew that most births in the private system happen by cesarean sections. It can be inferred however that, commonly, Manuela would be connected to more women that gave birth through cesarean

sections than through vaginal births. Apart from being exposed to bad or good experiences of cesarean sections, the cesarean birth mode is more visible to Manuela. The ‘effect of truth’, we follow in our western societies is that gathered information about a group can provide the frame in which ‘normal’ or ‘abnormal’ can be established. Our referential notion of ‘normality’ assumes that what is common is normal. During the whole pregnancy, Manuela was encouraged to negotiate her decisions and experience her body by comparing herself to what is common, and therefore ‘normal’. When facing an ‘abnormality’ (the fluid reduction), and the imminence of ‘abnormality’ (the labor that cannot end with the exit of the baby through the vagina), Manuela subjected her body to a cesarean section. Considering that, statistically, the majority of women in Manuela’s context had had surgical births, the decision for a cesarean section is common, and enables the experience of childbirth within a ‘normality’ curve.

4.3 End: the Exit of the Baby from the Mother’s Body

A Foucauldian analysis recognizes the immense influence of medicine on human social phenomena, yet, it provides a shift from the usual approach to childbirth by foregrounding the notion of ‘medicalized’ childbirth as a discursive notion. According to Fox (1997: 38), in a Foucauldian perspective, “the rules of discursive formation provide the conditions of existence of particular statements, which make possible to say certain things and not others”. I argue that the fact that the term ‘medicalized’ have become so widely used to refer to the way childbirth is carried out in today’s western societies, have contributed to establish two main understandings: a) That there is an authentic, a-historical, and ‘non-medicalized’ childbirth – namely, a universal physiology of birth – that in the course of time was taken over by medicine; b) that it is possible to return childbirth to its previous state, or in other words, to ‘de-medicalize’ it.

I argue that these two main understandings have heavily influenced feminist and anthropological studies concerning childbirth, and by consequence the care towards pregnant and laboring women. The repercussion of the understanding of childbirth as a universal and physiological event will be first demonstrated in this chapter. In the next chapter I will expand this analyses and as well explore the pursuit to ‘de-medicalize’ the birth event.

4.3.1 Medicalization Notion and the Concept of ‘Authoritative Knowledge’

Brigitte Jordan was a pioneer in the anthropological study of childbirth in the 1970’s, making childbirth visible as an event in need of exploration by the social sciences, in an era when pregnancy and childbirth was undervalued as an anthropological field (Davis-Floyd and Sargent 1997). She developed the notion of “authoritative knowledge” claiming, “in any particular social situation a multitude of knowing exist, some carrying more weight than others” (Jordan 1997: 60). For her, knowledge is produced in a system of practices, conveying status to a particular social group, and is consensually taken as valid (Jordan 1997).

Jordan (1997) explains her conceptualization of ‘authoritative knowledge’ by describing a birth in a hospital in the United States by the end of the 1980’s (Jordan 1997). Her research was based on observation of “knowledge systems” and the hierarchical organization of knowledge, describing two knowledge systems, one gaining ascendance above the other (Jordan 1997: 56). She observed that all participants of a particular childbirth - the doctor himself, nurses, the husband and the laboring woman - valued the knowledge of the doctor, stated by her as “medical knowledge” (Jordan 1997: 61). Jordan describes the woman’s knowledge as being what the woman was experiencing in her body. She argued that the woman’s knowledge was devaluated because “the woman’s body’s natural responses” were ignored and suppressed by the other participants of the event (Jordan 1997: 74).

Jordan's rationale for conceptualizing 'medical knowledge' and 'woman's knowledge' as two systems apart, where the knowledge of the doctor is learned from medicine and the woman's knowledge is her bodily given experiences, exposes the repercussions of the 'effects of truth' of discursive formation (Fox 1997: 35) and exemplifies the argument above. Her analysis, I suggest, unveils the same core values of the 'medicalization' notion: the existence of an authentic corporeal experience that is dominated by a social construction, named the 'medical knowledge'.

Jordan (1983, 1997) does not directly address the issue of power as such, whilst Foucault (1990) argues for an understanding of power/knowledge as "a phenomenon that cannot be reduced simply to either component" (Fox 1997: 35). His theory departs from Jordan's in her notion of corporeality. Rather than her understanding of the prevalence of the "doctor's authority" in the birthing situation, it is her notion of the woman's knowledge in terms of bodily experiences that separates the two perspectives. In a Foucauldian analysis, there is no woman's knowledge or bodily experiences outside medical knowledge, because the body, in this perspective, is produced by medical power/knowledge (Fox 1997: 40) and because "it is impossible to know the materiality of the body outside its cultural significations" (McNay 1992: 30). "Women everywhere give birth to children" (Moore 1988: 29), but the way women experience birth cannot be taken for granted as a form of authentic and universal physiology because this physiology is recognized and elaborated in distinct manners (Moore 1988: 29), and women's bodies cannot be understood outside its contextual account.

4.3.2 Manuela's Active Role

Manuela's childbirth narrative features an example that childbirth needs to be explored within a perspective that understands biomedicine as framing bodily experiences. For instance, there has been a continuous effort to "affirm women's voices" in the study of

childbirth, making childbirth visible from a woman's perspective, foregrounding their subjectivities (Cosslett 1994: 2-3). However, most of the research attempting to explore women's subjectivities during childbirth through narratives or participant observation has predominantly focused on vaginal birth experiences. Towards the end of my interview with Manuela, she narrated the precise moment of the exit of the baby from her body. Can Manuela's cesarean section story be accounted as a woman centered childbirth? Can Manuela be the main agent of the childbirth she experienced? If Jordan's notion of the woman's knowledge is considered, what would Manuela's knowledge stands for since her body does not have "natural responses"? If a 'medicalization' perspective is considered, is Manuela's birth purely medical, since there is no physiological birth happening? How did Manuela experience her anesthetized body in the moment Leo came out? How could a body that cannot perceive its own materiality provide an account of its experience? The excerpt below is the narrative that follows right after Manuela had stated that her cesarean section was scheduled:

(...) So, it was in the evening [the birth]. Actually, I was very scared. Because I was waiting, "somehow this baby will have to come out..." My mother was always saying: "It will come out somehow". I wasn't prepared for that! We know that it will come out, but when the time came I was very scared. (...) Then we got admitted [to the hospital] at five [pm], at six they took me to the surgical center and I stayed forty minutes alone there! I think it wasn't necessary to take me so early if the cesarean was supposed to be at seven. Because I'm scared to death of needles! Roberto had to stay outside and there was nobody to hold my hand to insert the catheter! Terrible! So, that was not so good. But it was a bit interesting because I was there and there was two babies being born during those forty minutes. I cried on every birth. I thought: "The next one is mine! My God! The next one is mine!" It was really nice. (...) But it was really nice that the staff at the hospital were very cool. (...) Some people had scared me with the anesthesia I had to take. It was actually really smooth. I think it depends on the sensibility of each body... [the effect of the anesthesia]. But the nurses were really nice. I came already saying: "I'm scared to death of needles!" Then they were very relaxed. (...) I hugged one nurse in front and the anesthesiologist was on my back. (...) Then my doc came and that was cool. Then, they started to prepare the stuff. Then Roberto came. They call the father, but only when it is almost the moment to take the baby out. They [fathers] don't stay

when they start cutting for instance. They don't allow the fathers to see that. There was a huge piece of cloth in front. But I was really nervous. It was anxiety. It was fear. For me, that moment for me was a changing point. From that moment, something completely new and different would start to happen. And it was really nice because when she took Leo out, then they lowered down the cloth so we could see, she [the doctor] said: "Wow! Such long legs!" Then I: "So long legs!" And she: "So much hair!" And I: "So much hair! And it's black!"; because Roberto and I were born very blond. And he [Leo] was born with a lot of hair and very black hair. Then it was really nice when they wrapped him, he was crying a lot, they brought him to me, he was really crying, then I said: "Hi Leo." He stopped crying. It was... magical! Wonderful! It was really nice.

Comparably, Mattingly (2010) makes use of narrative theory to argue that narratives are both told and lived, following Ricoeur's (1984) understanding that we live and act as in the midst of a "yet untold story" (Mattingly 2010: 123). According to Mattingly (2010), evidence that we live in order to create stories is grounded in the way we experience time. Long or short time is experienced with reference to what is happening, rather than the clock. The way we experience time, our lived time, is narrative time rather than chronological or physical time (Mattingly 2010: 124). While chronological or physical time is linear, with one event progressing to the next one, narrative time and our lived time is rather a web in which many particular events can be seen as part of creating a whole. For her, a plot governs both narrative time and lived time. In other words, when we tell stories we include the events that are relevant to the moral of the story. When we experience life we take decision and directions in order to "create sense out of situations" (Mattingly 2010: 123), or "after the manner of a narrative", as Ricoeur writes (1984: 3).

Manuela's narrative is not only an account of an event that happened, but Manuela's narrative is also an account of her actions. Her narrative is a story she tells and it is a story she have lived. When Manuela told me her story, she presented herself to me, and by so doing she presented 'her self' to me. In Manuela's narrative, her identity and subjectivity is emergent.

4.3.3 Medicine as the Medium Where the Body is Performed

In Foucault's theory, the body is a social and cultural creation of power/knowledge (Fox 1997: 40), which cannot "yield its essential features to naked observation unmediated by forms of knowledge" (Armstrong 1997: 21). In other words, there is no experience of the body without knowledge/power. However, as noted by Fox (1997: 40) Foucault "seemed entirely unconcerned about whatever kind of material entity the body might be". Foucault did not develop a notion of materiality or corporeality of the body (Fox 1997) and many of his followers have arrived at different conclusions on this matter (Armstrong 1997). His notion of knowledge/power as a productive will rather than an oppressive force however, have provided inspiration for many writers after him (Armstrong 1997), providing new pathways for understanding knowledge.

The Dutch philosopher Annemarie Mol (2002) for instance, trails Foucault's route describing knowledge as producing practices, not as an entity placed in minds or words, but incorporated in practical events (Mol 2002: 32,48). For her, "the material organization of medical practice shapes the reality" (Mol 2002: 48). She also argues that what people say when telling stories doesn't only reveal their perspective or a set of meanings, "but also tells about events they have lived through" in practical terms (Mol 2002: 15). Events they performed. In this sense, Manuela's childbirth becomes something that she does, and her identity, what she is, is constituted in and through her practice.

If only the 'medicalization' perspective is considered in Manuela's story, and if childbirth is assumed as a physiological phenomenon that is dominated and transformed into a medical event (as the 'medicalization' critique suggests), and since Manuela did not experience a 'physiological' birth, she is left with only one meaning: With what her childbirth meant to her. In this perspective, her body is left out. However, if medicine is viewed as producing the body as we experience it, and if Manuela is viewed as performing her childbirth, the reality of Manuela's anesthetized body is as vivid as of a woman giving

birth vaginally. Thus, arguing for a view of the childbirth event neither as simply biological nor social, but as a phenomenon only experienced within medical concepts, I claim for a unified view of the body. I hence agree with McDowel (1999: 40) when she states that we experience our bodies “in space”, and as well “as places”. Manuela does not only possess a body as a biological entity separated from her mind, but her own identity is performed in and through her body.

In the field of childbirth, changes in the body urge women to renegotiate the way they perform themselves. Kukla (2005) has argued that pregnancy and childbirth are phenomena when women are especially vulnerable, and medicine enables the proper means to experience them. Although many feminist scholars have deconstructed the notion of pregnancy as an abnormal state, Kukla (2005) insists that one dimension of abnormality in pregnancy - the experienced “uncanniness” - has to be recognized (Kukla 2005: 138). She considers pregnancy, childbirth and yearly maternity as conditions of enormous volatility of self-image and identity (Kukla 2005: 138). During these periods, our sense of self is drastically questioned, as we have to renegotiate our social, personal and public identities as well as cope with basic and concrete perception of the bodily self (Kukla 2005: 138). It is during these periods when women strive to rebuild their senses of self, that shared public representations of pregnancy, childbirth and maternity seem compelling, and that medicine substantially provides the boundaries to accommodate and configure their vulnerable identities (Kukla 2005: 139).

Before getting pregnant, the way Manuela performed her self was a stable practice. With the pregnancy, this practice required extra efforts, new and different actions, in order to maintain a sense of identity with such an unfixed body. A body that grows and expands. Medicine has provided her with the frame: She does a test and the pregnancy started in May, she does the ultrasound and the baby can be seen, she does the resting, the sleeping. Medicine sets the stage to perform the pregnancy. She is pregnant. Manuela does many ultrasounds.

The fluid reduction is in three of them. The doctor asks what is her decision. Manuela can do both: She can do a normal birth; she can do a cesarean section. Medicine shows the norm: The others do cesarean sections. The doctor has an agenda. At 7 o'clock, childbirth will be carried out.

When the day comes and when the time comes, every one has a deed. The nurses do the preparing. They prepare Manuela. They prepare the knife. Manuela cries with the crying of other babies. When does one stop being pregnant and turns into a mother? Roberto does the waiting. He waits outside. He waits inside. Manuela also waits. Manuela acquiesces. She puts on the hospital outfit. She is pierced. Objects also have a deed. The needle opens the skin to insert the catheter. The cloth does the covering. The knife cuts. The doctor does the opening. The belly is opened. The doctor takes the baby out. The cloth is lowered down. The doctor sees the baby. Manuela sees him too. The baby cries. Manuela talks to him and he stops. The childbirth is over. From now on maternity will settle in.

In this chapter I have discussed the influences of the notion of 'medicalization' as having provided a space for critically scrutinizing how childbirth as a universal physiological event have come to be dominated by medicine. In addition, I have also shown that such an understanding may be problematic and narrow, overemphasizing the power in medicine as a negative feature. I have further discussed how this view may contribute to a limited interpretation in Manuela's case, producing an understanding of Manuela as passive and powerless before an oppressive medical power. In order to overcome the problems of the 'medicalization' perspective, I have suggested in this chapter that childbirth in the Brazilian setting needs to be analyzed within a broader, but also a more nuanced approach. I have portrayed the power of medicine as a productive force, providing the standards to produce and experience the body and its phenomena, medicine as the main medium through which the reality of the body/self is experienced and performed.

CHAPTER FIVE: THE HOME BIRTH NARRATIVE - A MEDICALIZED NATURAL BIRTH METAPHOR

I see birth in many ways. First, the birth in itself for me is something sacred. I see the birth of a child as the first spiritual, physical and emotional contact with the world it is coming into. So, I see birth as a mark that reverberates on a person's life.

Carmen, midwife

My interview with Jessica was in one of the biggest shopping malls downtown. As we had never seen each other before, I must admit the first time we met, I could hardly believe it was she. To my eyes she looked too young to have had a home birth, if not a birth at all, wearing skinny jeans and sneakers, and carrying a backpack. The reason for my surprise is that in Brazil, home births are not the norm, although some authors argue that it is underreported (Carr and Riesco 2007). Nevertheless, a home birth in a big city as Curitiba is a rare event. Jessica seemed too young to overcome all the social, cultural and practical hindrances to achieve a home birth in a metropolis. When she introduced herself I came to know that she was not as young as I expected. We sat down at a café. As she told me her story, I could follow her emotional and practical paths through a birth narrative that was far from regular. It was my longest interview.

In this chapter I will discuss the notion of 'humanization'. Through the practices foregrounded by Jessica's narrative, I will argue that this notion has deep roots in core values of the 'medicalization' critique, especially the understanding that childbirth needs to be 'de-medicalized'. In addition I will look into a program established by the Brazilian government that attempts to implement 'humanized' measures into the practice of childbirth in the country. I will claim further that the notion of 'humanization' in the field of childbirth was nourished and perpetuated by the feminist movement, which embraced 'humanization' as the counterpoint to 'medicalization'. I will also describe the influences of the 'natural childbirth movement' on the practices advocating for a 'humanizing' of childbirth.

5.1 Beginning: a Way to a ‘Humanized’ Birth

In contrast to Manuela’s story, Jessica’s birth narrative was full of unexpected events. While Manuela had a steady narrative flow that seemed to walk the same path all the way to the end, Jessica seemed to take a new sideway on every corner. While Manuela’s pregnancy was described as “smooth”, as an event that she could enjoy while waiting for childbirth, Jessica’s pregnancy seemed a bumpy ride. Jessica had a lot to consider, a lot to decide, a lot to credit while she was pregnant. She translated a lived troubled time in a dramatic narrative, “which propels the protagonist in a quest to obtain her goal through the overcoming of a series of obstacles” (Mattingly 2010: 132). In Jessica’s story each obstacle she described, became a new story that I had to explore further at the end of the interview. For this reason, in order to make Jessica’s narrative more clear for the purpose of this chapter, I will explore her story in a different way I analyzed Manuela’s story. Instead of just following her narrative event after event continuously, I will condense some fragments that were told in the beginning with pieces from the end of the interview. In this first part of the analysis, which encompasses Jessica’s pregnancy and decision for a home birth, I will summarize some moments, writing a narrative myself that glues Jessica’s highlighted excerpts.

Jessica’s pregnancy was unplanned and happened when she was 20 years old, while she was still studying. She hid the pregnancy during the first 3 or 4 months. Jessica explained to me that after she had accepted the pregnancy, she used most of her time reading about childbirth on the Internet. Jessica’s sister had had a vaginal delivery before her, and her sister’s experience of episiotomy frightened her. In order to avoid the procedure, Jessica had decided to have a cesarean section. For her, the time she spent “gathering information” on the Internet during pregnancy was determinant for her to change her mind, from wanting a cesarean section to settling for a childbirth mode with no interventions at all. She said:

I grew up with my mother telling me that normal birth was much better than cesareans. I repeated that my whole life. Until I heard my seventeen years old sister saying: “My son was born very fast. I got there, the doctor made a small cut and he was born”. And I said: “What? What did she cut?” That stuck to my head, you know? Then when I got pregnant, first thing I thought - after the stressful beginning when I didn’t tell anybody I was pregnant, the rejection and all - when I started to read about childbirth, it was the cut. I started to read and I discovered that episiotomy was routine and I got desperate. First thing I told my boyfriend was: “My God! What am I going to do? They cut us down there! I want to have a cesarean!” It was the conclusion; it was the logic thing. (...) After, I discovered that the cut was [called] the episiotomy, and that episiotomy was not necessary and all the problems that could come from it. After that, I started to search more about the humanized birth, what were my options here in Curitiba, and what was a doula. It was after this initial point that my study followed, you know?

Before traveling to Brazil, I was aware of the discussions on ‘humanization’ of birth from the research I had read and from the time I was an intern student in maternity wards. Besides asking women to tell me their birth stories, I was curious about their opinions and understandings on this specific notion. Jessica mentioned the term ‘humanized’ birth many times during the interview. It seems that the Internet material Jessica read and later became connected to, advocate for vaginal delivery and for a process of ‘humanization’ of birth. The term ‘humanization’ of birth (*humanização do parto*) or ‘humanized’ birth (*parto humanizado*) is widely used in Brazil, and is a topic on Internet blogs and media as well as in research and academic publications, and movements that promote vaginal birth are systematically connected to this notion (Diniz 2005, McCallum 2005). In the following, I will discuss the influence of feminism in idealizing and promoting governmental measures that bring ‘humanization’ as a notion onto the political agenda in Brazil.

5.1.1 ‘Humanization’ in Theory

As mentioned in Chapter Three, women’s movements have changed in the years that followed its emergence during the dictatorship period. The Program for Integrated Women’s Health Care (PAISM) was created in 1983 (Osis 1998), in order to ensure a greater representation of women’s health issues in the government. Representatives of women’s

movements and medical and social science professionals developed the guidelines for the program, implemented in 1984 by the government (Osis 1998). According to Osis (1998), a scholar working in maternal health in Brazil, the purpose of the program was to provide practical measures, as well as fulfillment of moral and deeper claims of the Brazilian society, concerning women's health (Osis 1998: 26). The program was driven by two main topical goals: Integrality and autonomy (Osis 1998, Serruya *et al.* 2004), which I suggest, have been greatly influenced by feminist agendas, attempting to move away from the mode of healthcare towards women viewed as 'medicalized'.

The very own goals of PAISM (integrality and autonomy) exemplify this move: First, the concept of integrality in the program meant that women and women's health should be understood not merely on basis of their biological reproductive functions, but also as having social and psychological needs from birth to death. Integrality pushed women's health care onto a multidisciplinary arena, confronting medical hegemony; Second, the program's pursuit for women's autonomy, demonstrates the attempt of making women accountable for their own health. Both integrality and autonomy reflect measures promoted by advocates of the 'medicalization' theory, which conceives medical power as negative and oppressive (Lupton 1997: 96). According to Lupton, most critics of the 'medicalization' underscore the need for a greater regulation of medical profession, challenging the right of medicine to define disease and illness and encouraging patients to take control over their own health (Lupton 1997: 97).

However, the aims initially suggested by PAISM meant an array of practical challenges. Some authors claim that after many years of its implementation, PAISM has failed in achieving its main goals (Berquó 1993, Costa 2009, Serruya *et al.* 2004, Vieira 1999). It is in this context, that the Brazilian Ministry of Health in 2000 launched the Program for Humanization of Prenatal and Childbirth Care (PHPN), in response to society's growing concerns about the way childbirth was conducted in the country. The practices that were performed in childbirths in Brazil were portrayed by many as violating women's

integrality and autonomy, the two central values that PAISM set out to implement, and its failure to do so is believed to massively influence maternal and child mortality rates (Serruya *et al.* 2004). Serruya and colleagues (2004) understand the institutionalization of PHPN as a mark that brings “the paradigm of humanization as the new model of care towards women during pregnancy and childbirth” (Serruya *et al.* 2004:1282, my translation). In PAISM the term ‘humanization’ of care had already been used, yet through PHPN the notion of ‘humanization’ was brought onto a more visible political agenda in the field of pregnancy care and childbirth (Andreucci and Cecatti 2011). Serruya *et al.* (2004: 1282) quote the presentation of PHPN by the Ministry of Health¹⁸:

The program is based on right to humanization of obstetric and neonatal cares as the first condition to an appropriate follow up of childbirth and puerperium. Humanization consists of, among others, two fundamental aspects: The first one, it is concerned with the health unit’s duty of welcoming women, newborns and their families with dignity. This aspect requires an ethical and solidary attitude from health professionals and institutions, in order to create a welcoming environment, and hospital conducts that break with the traditional isolation forced on women. Secondly, it is concerned with the introduction of measures and procedures that are known to benefit labor and childbirth, avoiding interventionist practices that though traditionally performed, do not represent benefits to women and newborns, carrying on risks to both.

The notion of ‘humanization’ is described above as a model of care that encompasses women’s dignity, ethical professionals, a welcoming environment, and safe and beneficial procedures (Serruya *et al.* 2004: 1281). This notion can be interpreted as associated with proper attitudes - described as an ethical duty - from professionals and medical institutions towards pregnant and laboring women, and hence establishing dignity for the women. In addition, the document supports “measures and procedures” that are beneficial, while “interventionist practices” should be avoided.

¹⁸ I have translated this quotation from Portuguese to English.

As discussed about PAISM, the notion of ‘humanization’ in PHPN also unfolds characteristics borrowed from the ‘medicalization’ theory. Lupton (1997: 96) argues that “the notion that individuals should not have their autonomy constrained by more powerful others is central to the ideals of the medicalization critique”. In PHPN, women’s dignity is seen as dependent on a proper conduct of medical professionals and institutions. This view positions health professionals as having the power to bestow women’s dignity. It can be inferred that this power is seen as in need to be lessened, in order to respect or honor women. As already mentioned, this view of power, as an oppressive force, frames the main arguments contained within the ‘medicalization’ critique.

I contend that although PAISM and PHPN represented remarkable improvements in the care for pregnant and laboring women in Brazil, the core of these programs are in fact a reflex of feminist claims and concepts. The notion of ‘medicalization’ in feminist writings laid the foundation to bring to life ‘humanization’ as its counterpoint, yet with certain repercussions, a point that I will return to below and in the next chapters.

5.1.2 ‘Humanization’ at Home

Mattingly (2010) speaks of story time as structured by a movement from one state to a transformed state, meaning that things at the beginning of one’s story are different at the end (Mattingly 2010: 131). Jessica’s narrative starts with an unplanned pregnancy, and a fear of having to experience an episiotomy, generating a desire for a cesarean section. Her story shows the movement from this state, which arrives at a home birth at the end. It seems that Jessica’s story describes her transformation from: a) being a person that by fear of one medical intervention performed in the hospital (episiotomy) wanted another medical intervention (cesarean section); to b) a person that by knowing the medical practices performed in the hospital, decided for a home birth. Jessica’s story is about the transformation she experienced and how this transformation came about, of how her desire

for a cesarean section was transformed into an understanding and wish for a ‘humanized’ birth. The meaning, the moral of one’s story however, is not achieved only at the literal end (Mattingly 2010). The essence of Jessica’s story is not located at the end of her interview. The very sense in Jessica’s narrative comes right at the beginning, because she clearly exposes the plot she is about to create: The plot of Jessica’s story is her quest for a ‘humanized’ birth, which she succeeded in having at the end.

Jessica explained to me that through Internet groups she came to understand about ‘humanized’ birth and started to search for possibilities. Also through the Internet, Jessica met Noemi, the doula that introduced her to the group of nurses, the Butterfly Group¹⁹, which came to assist her during childbirth. Jessica mentioned that as she did not have health insurance, and could not afford a private hospital, she would give birth in a public hospital. Health plans in Brazil work in a way that a person has to wait for a defined period of time, paying the plan for some months before having the right to use its benefits. In practice, it means that if a woman finds herself pregnant and she is not already enrolled in a health plan, which was Jessica’s case, she cannot simply start paying. She will only have the right to receive obstetric care through the plan only after some months, after her child is born. Full private care is very expensive. Some of the women I talked to mentioned that a privately paid childbirth would cost around 8000-10000 reais (local currency), which means between US\$ 3000-3500, which does not include anesthesiologist, complications or prenatal care. According to Jessica and Carmen (the nurse from the Butterfly Group I interviewed) a home birth costs 3500 reais (US\$ 1200), including three prenatal and one postpartum appointment at home. Both also mentioned that it is previously agreed that if any emergency happens, the woman would go to a public hospital if she is not enrolled in a plan, or to a private if she does.

¹⁹ As mentioned in Chapter two, the Butterfly Group is a group of four gathered obstetric nurses that assists home births in the city of Curitiba.

In the public system (SUS) in Brazil, women are assigned to give birth in the closest hospital to their private address. Jessica was assigned to Saint Marta's Hospital, which according to her, was known by its large use of interventionist practices. Jessica explained that at that moment, she started to despair. She said:

By then, I was already six months pregnant. And I was desperately thinking: "Is everything going to be okay? Am I going to be respected during childbirth in SUS?" Then, people in these groups [internet groups] usually, at a first glimpse, they seem a bit rude. But it is not that. It is because they want to open your eyes as fast as they can, because you have a deadline. You have forty weeks you know? [They say in the groups:] "No, don't do that [don't try to give birth on SUS] because you're going to get screwed". Then I talked to a doula, because I ended up by chance reading her blog. (...) Then I made contact with her, and she said: "Let's talk, let's find a date". And that was when I broke down in front of her and she saw that no way could I face a traumatic childbirth. The pregnancy had been already unplanned, and I would have a birth marked as something bad? So she offered to attend to my boyfriend and me. Until then, the possibility of a home birth had never crossed my mind.

Jessica and Noemi talked to the chief nurse in the health unit Jessica had her prenatal follow up, trying to transfer her assignment to another public hospital, Saint Phoebe's Hospital. According to Jessica, this second hospital is more 'humanized', meaning that some interventionist practices are avoided, alternative procedures are encouraged, doulas are accepted and the hospital has a few nurse midwives working, that if present, could assist Jessica instead of a doctor. Jessica told me that she felt anxious about all the uncertainties around having her childbirth in the hospital, and by not being able to settle down with this option, talked to the nurses of the Butterfly Group and decided for the home birth:

This was when I talked to them [the Butterfly Group] and when the idea sank in: The only way I would be a hundred percent respected, without having to pay private, which would cost at least eight thousand reais [Brazilian currency], which we couldn't afford, neither we could dream of taking this money out of nowhere, was a home birth. Then we talked to them [the Butterfly Group], I cried a lot, I was very scared... They said: "If you want to be respected, or you go to Saint Phoebe's and put your foot down, being at risk of getting a staff that won't assist you in the way you want, or you have it at home. Those are your options." (...) Then we got home and I told my boyfriend: "Man! What are we going to do?"

Then he said: “Let’s do it at home!” (...) So, after some days we said: “We think we’re going to do it at home”.

Along her narrative Jessica clearly associated the notion of ‘humanization’ with an idea of ‘respect’. She said that she was concerned about having “her birth respected in SUS” and since she could not afford a private childbirth the only way to be “a hundred percent respected” was to have a home birth. I interpreted Jessica’s use of the expression ‘to be respected’ (*ser respeitada*) to mean concern - from professionals attending her during childbirth, about her feelings, wishes and her right of choosing to avoid interventionist practices. It seemed that for Jessica, having her opinions and will respected with regards to avoiding interventions by those who would attend to her was imperative in her own understanding of what a ‘humanized’ birth entailed. In this sense, Jessica’s notion of ‘humanized’ birth is coherent with the government’s quotation mentioned above. Since dignity in the government’s notion of ‘humanized’ birth represents a proper attitude from professionals to women, the ‘respect’ from professionals towards Jessica’s wishes would ensure her dignity. In addition, Jessica also portrayed in her story the second dimension of ‘humanization’ described by the government – respect for her choice of avoiding interventions.

Jessica’s narrative exemplifies the differences between theory and practice that marked the history of PAISM, and by consequence of PHPN, extensively criticized by some authors (Berquó 1993, Costa 2009, Serruya *et al.* 2004, Vieira 1999). Although PHPN stresses ‘humanization’ as foundational, Jessica felt that this kind of treatment could only be achieved outside the government’s health care system. Since the main goal of the program was to reduce maternal and child mortality, the practical strategies recommended by the government are focused on ensuring a certain number of pre-natal and post-partum appointments, pre-natal screening and access to hospital when giving birth (Andreucci and Cecatti 2011, Serruya *et al.* 2004). While highlighting the ‘humanized’ way of conducting childbirth and

pregnancy as a standard, the government refrains from providing practical recommendations to achieve ethical and proper attitudes from professionals.

The ‘humanization’ described in PHPN meant in practice more access to appointments, examinations and hospital admission, and all these assets were available to Jessica. Nevertheless, she seemed to refuse the entailment of dignity through access. Jessica incorporated the whole notion of ‘humanization’ as it is described in PHPN, seeking a mode of care that was beyond access, pursuing respect for her choice to avoid any interventions, something that she perceived she could only achieve at home, and not at a hospital. She said:

People think we choose without thinking. It’s not like that. It’s exactly the opposite. (...) It’s exactly because I got so much information that I chose a home birth. Because I realize that even if I fight inside an institution, if I didn’t want to pay an absurd, and even if I pay, I would have the risk of everything going wrong at the end. (...) So, it is the last chance for those who want to give birth with dignity, to choose a home birth, because you know you are going to be respected.

5.1.3 ‘Humanization’ in Practice

The feminist anthropologist Judith Butler (1999) speaks of ‘representation’ of women as a double-edged term. While representation means the “political process that seeks to extend visibility and legitimacy to women” (Butler 1999: 3), it also signifies the description or portrayal of women in a specific and defined way. In her book, Butler argues that feminism, by gathering all its subjects under the same category named ‘women’ in order to represent them before the law, has produced what is understood as belonging or not belonging to the category ‘women’. Following Butler’s claims, I contend that, through PAISM and PHPN, feminism in Brazil have contributed to the field of childbirth in a double-edged way: a) It has contributed to more representation in the Brazilian government facilitating claims for changes in the field, and which indeed has served to provide improvements in women’s health; b) it consolidated the notion that the care towards women in the country was highly ‘medicalized’. I therefore contend that the very notion of ‘humanization’ is born out of an assumed need for

‘de-medicalized’ childbirths, and that the repercussions of this process are both beneficial and debatable, a point I will return to shortly.

While the government, through PHPN, incorporates ‘humanization’ as a response to feminist claims, in the reality experienced by women, theory and practice seems to clash. Although the government endorses the ‘humanized’ care, where women’s treatment is less ‘medical’ and more ‘humane’, the practical implementation of the program, however, entailed more ‘medicalization’ through more examinations, and more appointments and hospital childbirths, as part of the goals in reducing child and maternal mortality rates in Brazil. In this context, Jessica’s narrative features a vivid example: Her quest for a ‘humanized’ birth became a quest for de-medicalization since in her understanding of a ‘humanized’ birth, dignity could only be ensured by ‘respect’ in avoiding interventionists medical practices – something that could only be achieved outside the government’s hospital system.

5.2 Middle: Protecting the Physiology of Birth

After having explained all her struggles with accepting her pregnancy, and how she had arrived at home birth as the logical choice, Jessica arrived at the moment where she narrated the birth in itself. She started this part of her story by describing the context: Where she was and what she and her boyfriend Gabriel were doing during the birth. Jessica had mentioned however, that as she and Gabriel were living at their family’s house by that time, she did not feel comfortable in having the baby there. Noemi, her doula, had then offered her own house, and Jessica labored and gave birth at her doula’s house. Although the labor started where Jessica was living, after calling Noemi and the nurses of the Butterfly Group, Jessica was driven by one of her in-laws to Noemi’s house. The following excerpt, describes the beginning of her labor and the route to Noemi’s house:

So, I was at home. (...) We ate something and we sat down to play some computer games to relax. Suddenly, I stood up behind him [Gabriel] and started to feel a pain in my belly, I didn't know what it was. He looked at me and said: "Is everything okay?" I said: "Yes". I was relaxed because it had been already two, three weeks that I had been feeling pain on my pubic bone. It was because he [the baby] was engaging. I thought it was the same thing right? So, it passed. Then, I think five minutes later I had another pain. Then I went to the room and crouched on the bed and started to scream. He said: "What is going on? What do I do?" And I said: "Find a clock, do something! Try counting time!" But there was no time to do it, because the contractions started, there was not that thing of each five minutes, or each time, or each minute. It was one after the other. There was no time between them. It was very weird. Then I went to the shower with him [Gabriel]. We stayed for some time, and it was, contraction, contraction, contraction... and screaming! Then he said: "I think I'm calling Noemi..." And I said: "Call". I hadn't asked him to call because it was a bit weird, I thought it was not the time, I don't know... I didn't think I was in labor. So, he called her. Then she said: "Look, it sounds a bit weird, but if she is in pain, it is probably labor. I think you should call the nurses" (...) So, he called the nurse Adriana and she said: "Look, she is in labor. You should go to Noemi's. We're heading there." So he called the other nurse, Ana Maria, to tell her we were going to Noemi's. So she asked to talk to me in the shower. By then, on the previous call to Adriana, my water broke. (...) Then the first thing I did was to put my hand down there to check the color of the water. Then I saw it was transparent and I relaxed. Then I started crying. Because I was thinking: "Now I'm in labor..." (...) Then it did sink in that I was in labor and that he was going to be born. Then I thought: "My god! I didn't clean the..." because they [the nurses] ask for a plastic, to wrap the mattress. I hadn't cleaned the plastic yet. It had passed two weeks since we bought the plastic and it was there to be cleaned, to be disinfected with alcohol. So while I was in the shower my in-laws cleaned the plastic, put it in a bag and we got the bag. I left the shower, just put a dress on, I didn't even really dry myself, and we went to the car. (...)

The above excerpt could have been part of a hospital birth narrative. Labor starts, some calls are made, some things are packed, and the laboring woman and partner leave home to some place else. The elements that make Jessica's narrative distinctive are the place she went to and what she brought with her. Jessica left her house in labor to go to her doula's house and she brought with her a plastic to wrap the mattress. The first dimension drawn from Jessica's narrative I will emphasize in this section refers to the place where her childbirth happened. The second refers to the practicalities of a home birth, which I will discuss in section three.

Jessica experienced a home birth. The childbirth she experienced however did not happen at her own home, but at Noemi's home. As I mentioned before, in Jessica's quest for 'de-medicalizing' her childbirth experience, there was a requirement to avoid interventionists practices, only achieved outside the medical domain. By choosing to give birth at Noemi's house, Jessica makes visible her concern about delivering her baby outside the hospital, rather than valuing the familiarity of her family home. For Jessica, having a 'humanized' birth was not about having a home birth, but rather an 'outside-the-hospital' birth.

In the previous chapter I discussed Lupton's (1997) proposal of making use of Foucault's theory of power to explore medical practices, and analyzed Manuela's narrative as an experience that emerges within the power/knowledge of medicine. I have used Foucault's theory to describe 'medicalization' as a discursive notion, connecting this notion to three aspects of Foucault's "Ontology of the discourse" (Fox 1997: 36): a) It is embodied in daily practices; b) it is a manifestation of knowledge/power that cannot be reduced to human intentionality; and c) it is diffused producing effects of truth (*ibid.*). With regards to Manuela's narrative, Foucault's perspective has enabled for a broader interpretation of power and highlighted some of the drawbacks of the notion of 'medicalization' found in much research, especially feminist anthropological research about childbirth.

Here, I argue that Jessica's focus on having her baby outside medical observance reveals a *practical* deployment of 'medicalization' as an imprinted notion. It seems that giving birth in the hospital meant being exposed to medical interventions in a coercive way, against the individual's will. I claim that Jessica's inference that a respectful and gentle birth can only be achieved outside the hospital, or by an expensive 'de-medicalized' staff, disclose an understanding of doctors and medical institutions as oppressive, a matter central to scholars of the 'medicalization' critique (Lupton 1997). Jessica, Carmen (the nurse that works at the Butterfly group) and Tatiana (the doula I interviewed) spoke of doctors as

performing interventions that according to them are unnecessary to the course of the birth process, and often against the laboring woman's will. It appears to be fundamental to advocates of 'humanization' of childbirth an understanding of childbirth as a physiological event, prior to bio-medical expansion and dominance.

According to Lupton (1997), it is in the perception of the body that 'medicalization' and Foucauldian perspectives depart ways. In the first perspective, the body is rooted in a non-historical nature (Duden 1991: 3) that it is dominated by medical power and which ought to be regained by patients. In a Foucauldian perspective, however, the body is the product of medical knowledge/power, and only experienced within this frame (Lupton 1997, Duden 1991). The quest for a birth outside the hospital where medical interventions are avoided, as exemplified by Jessica's narrative, reveals the influence of the 'medicalization' notion in understanding the body as the site of an authentic/non-historical physiology, that throughout time has become the domain of bio-medicine, and which ought to be restored to women's own agency.

Jessica understood childbirth as a physiological event. For her, in a medical institution doctors have the power to convert this physiological event into a medical event through interventions. For Jessica, the physiological birth presented a risk of being disrespected in case medical interventions would have to be performed. In order to maintain her own childbirth as a physiological event, her childbirth had to happen outside the medical domain.

5.2.1 'Humanization' To and Fro

By no means I do intend to argue that Jessica understood that 'humanized' births were home births. She was very clear when explaining her notion of 'humanization' as attached to respect towards one's wish to avoid interventions, and not necessarily associated with the place where birth happens. In fact, Jessica criticized the popular definition of 'humanized' birth as associated with water or home birth. For her this definition is problematic because a

‘humanized’ birth does not have to happen in the water, or at home. For instance, Jessica mentioned the reaction of her doctor in the health unit, when she asked him to be transferred to Saint Phoebe’s Hospital. She said:

When I told to the doctor that I wanted to change the maternity to Saint Phoebe’s Hospital, because I wanted a humanized birth, he said: “You see, you will only have the baby in the bath tub if it is possible, only if the baby has the conditions to...” He gave me the whys and conditions for having the baby in the bathtub! Then I said: “But I don’t want to change to there for having the baby in the bathtub! Independent of anything, with bathtub, without bathtub, with shower... I want to go there [Saint Phoebe Hospital] because I have references stating that childbirth is more respectful there!” So, it is so wrong.... When people say: “I really want to have a humanized birth...” Then some people think: “Are you going to have a home birth? (...) Are you having your baby in the water? Isn’t your baby going to drown?” First, no, the baby is not going to drown and second, humanized birth doesn’t mean that you’re having the baby in the water. There is so much mismatched information. It is all messed up...

On the Internet and media I found references to all modes of birth as ‘humanized’, and besides often associations with home births and water births, other terms began to appear: natural childbirth, active childbirth, squatting childbirth, upright childbirth. Tatiana for instance, the doula I interviewed told me that she has abandoned the term ‘humanized’ birth using mainly the term ‘active’ birth (*parto ativo*). For her, ‘active’ birth features a better expression for the kind of birth she advocates, which is a process actively performed by women in their own domain. Tatiana told me that some might understand cesarean sections, procedures performed by doctors, as ‘humanized’. It seems that while the notion of ‘humanization’ may represent only respect towards someone’s will, such as women’s choices to have a surgical birth, ‘active’ birth describes an event where women are protagonists, which in her own understanding excludes cesarean sections. What was described by Tatiana, this notion of cesarean section as respectful towards women, is consistent with the current worldwide literature questioning if the decision for a cesarean section should be understood as a regard for women’s autonomy (Erskine 1999, Morrison and Mackenzie 2003), as I discussed in Chapter Three. Tatiana said:

The humanized birth is the one that respects the needs of the woman and of the baby. But it is a term that I ended up not using so much because it's too subjective. For lots of people humanized birth is cesarean, for example. That is humanized because that means to respect the woman. There are people who think that it [cesarean section] is a childbirth without trauma for the baby. But when I hear the term, what it comes to my mind, it is the respect shown towards the needs of the woman and the baby.

Although, as Tatiana stressed, some may portray cesarean births as 'humanized', I observed that this argument was mainly used as a counterpoint to a general view of 'humanized' births as vaginal births with no or few interventions. Even if many women may have professed their cesarean births as 'humanized' in blogs and internet group discussions, I could not find a single website advocating for 'humanization' of birth proclaiming cesarean sections as the main model. When I asked Manuela about 'humanization' of childbirth, her response exemplifies my observations. She said:

I think mine was humane, even though many people think it was not because I had a cesarean. But I think that even if it happened in the hospital, it was humanized. My baby was close to me all the time. He went to the room with me just after [the birth]. (...) He was with me after they had finished the cleaning procedures; he came with me to the recovery room, and then went with me to the room. We were always together.

While Manuela considered her own scheduled cesarean section as 'humanized' she expressed that this view is not consistent with general notions, which often associate 'humanization' with vaginal births that often happen outside the hospital. Jessica also highlighted that often people associate 'humanized' birth with bathtubs and home births. Manuela and Jessica's observations are consistent with most of the other women I interviewed. From women I talked to, most of them spoke of 'humanized' births as childbirths that happen at home, or in the water, with no interventions. Although Jessica stressed that home births and water births are not at the core of the 'humanization' notion, these common associations are not ungrounded. Nearly every website or internet group advocating for 'humanized' births are

illustrated with pictures and videos of women giving birth in the water or at home, as one of the women I interviewed, Patricia, exemplifies. When I asked what she knew about ‘humanized’ births, she told me:

(...) You are talking about those home births right? (...) I had never heard a lot about it. But then now when I was pregnant again, I read some blogs. I saw pictures of people having their babies in the sea, or at home! Like, pictures of the baby coming out of the mother! No! Not for me! I don’t think like that...

5.2.2 Associations: ‘Humanization’ and ‘Naturalization’

Apart from advocacy for the ‘humanized’ way of birth, most websites advocating for ‘humanized’ births also offer yoga, belly painting, shantala massage²⁰ courses, and other therapies considered ‘alternative’ to conventional western medicine. This connection of ‘humanized’ birth with ‘alternative’ practices that are observed on the Internet, in the media, and in the stories of the women I talked to, is nearly impossible to disassemble. It seems that the notion of ‘humanization’ of birth is associated with the ‘alternative’ realm in a way that makes ‘humanized’ and ‘alternative’ models inter-related.

Maria was the last woman I interviewed. She had twins, two boys; almost one year old by the time we talked. Maria told me that she had a cesarean section, because she was pregnant with twins and because she never wanted to have a vaginal birth. She believed that vaginal births were not safe. I asked about the opinions of others that she heard during her pregnancy when she had mentioned her decision for the cesarean section. Maria told me that a few people tried to convince her to change, and one of those was a friend that had had a ‘humanized’ birth. Maria told me that she thought her friend’s birth was “beautiful” but it was not something for her. Maria associated her friend’s birth mode to a set of characteristics that she did not incorporate, such as vegetarianism and yoga. It seemed that the notion of ‘humanized’ birth for Maria involved not only one’s birth practices, but also one’s way of

²⁰ Shantala massage is a kind of massage for babies developed by the French doctor Frederick Leboyer based on traditional Indian techniques.

living. I asked her opinion about her friend's 'humanized' birth and she said:

What I know is that she had a water birth, with doula... I think there was a doctor together with them. I think her obstetrician was assisting her. That's what I know. She is all... she is a yoga teacher, she has a hotel inn, she lives in Mariscal [a beach near Curitiba] and has a hotel inn there. She is all Zen, the hotel is all Zen, and she is vegetarian. She is the calmest person I know. I think... all these things you know? For me, that's a humanized birth.

In many ways, during my interviews and field work the notion of 'humanization' and 'alternative' views seemed to intertwine. The Brazilian anthropologist Carmen S. Tornquist (2002) claims that the notion of 'humanization' in Brazil unfolded from ideas of 'naturalization' of childbirth in the United States and Europe, dating back to the 1950's. Although she does not make use of the expression 'natural childbirth movement' as described in the additional literature I will discuss below, she speaks of the notion of 'humanization' as having deep roots in a social movement with certain characteristics: "Valorization of nature, critics towards medicalization of health, inspiration in non-western health care methods and techniques, inclusion of non-medical professionals in the health care" (Tornquist 2002: 486, my translation). The movement for 'humanization' was enthusiastically accepted by feminism in Brazil around the 1980's and after absorbed by governmental policies through the influence of feminist organizations (Diniz 2005, Tornquist 2002), which I have discussed before. Many of the women I spoke to, did not make a clear distinction, if there is a distinction at all, between 'humanized' births and 'natural' births. In many of my interviews and on the Internet, the term 'natural' birth was widely used as an equivalent to 'humanized' birth. It seems that the notion of 'humanization' expresses a process of reconstitution of childbirth as a 'natural' event, and as such a 'naturalization' of childbirth.

5.2.3 Natural 'Humanization'

The British physician Grantly Dick-Read is described as pioneering the ideas of a different approach to childbirth in the 1930's (Cosslett 1994, Tornquist 2002, Salem 2007). Dick-Read

defended a theory that stated that pain in childbirth was not physiological given, therefore arguing for the use of training techniques through which women would experience painless childbirth, without analgesic use (Dick-Read 2013). With slightly different techniques, the French doctor Fernand Lamaze also defended the same approach (Salem 2007). Dick-Read and Lamaze advocated for a 'natural' way of conducting childbirth, understood as a childbirth without medications and interventions. Both of them became popular in the United States and Europe, and their theories have greatly influenced ideas that came to stand in opposition to medical interventions in childbirth, crystallizing the 'natural' childbirth movement that gained ascendance from the 1950's and onwards (Cosslett 1994: 9).

Influenced by Lamaze and Dick-Read's work, a range of scholars, especially in the 1970's, searched for 'natural' ways to conduct childbirth, for example the doctors Michel Odent and Frederick Leboyer in France, the social anthropologist Sheila Kitzinger in England, and the doctor Moyses Paciornik in Brazil (Salem 2007). All these authors had their books published in Brazil, with several editions, and have remained very influential until today (Diniz 2005, Tornquist 2002, Salem 2007). Odent currently gives speeches, lectures and courses in Brazil, celebrated as an expert on 'humanization'. In 2013 for instance, a Brazilian documentary advocating for 'humanization' of childbirth was launched - Birth Reborn - borrowing the name from one of Odent's books. Alongside with other authors and professionals that advocate for 'natural' childbirths and a famous Brazilian actor whose wife had a home birth, Odent also gives briefs in the documentary film. The American anthropologist Robbie Davis-Floyd, well known for her studies in reproduction, childbirth and midwifery also participated in the documentary.

Salem (2007) argues that the view that women's incomprehension of their own physiology brings about their passivity in childbirth, and therefore their pain, is the main contribution of Dick-Read and Lamaze to the idea of a 'natural' childbirth. Both Dick-Read and Lamaze methods on how to overcome the pain in childbirth with no drug-use, were based

in the idea that pain is not an inherent phenomena in childbirth, but rather a social development (Salem 2007). Although both Odent and Kitzinger openly rejected the use of specific techniques to ‘control’ pain as proposed by Dick-Read and Lamaze, they consolidated the quest for a physiological and natural birth (Salem 2007).

Cosslett (1994) suggests that the notions of ‘medicalization’ and ‘natural’ childbirth form part of a parallel development. As the ‘medical’ way of conducting childbirth began to be understood as dominant and oppressive within the ‘medicalization’ perspective, a ‘natural’ way started to take shape (Cosslett 1994: 2). Cosslett’s claims are consistent with my own argument that the ‘medicalization’ notion is the medium through which ‘humanization’ can be conceived. The answer to the ‘medicalized’ way proposed by most scholars of the ‘medicalization’ critique is to provide for the emergence of ‘natural’ ways. Odent for instance, clearly exposes his embracement of Ivan Illich’s views, one of the main theorists within the ‘medicalization’ critique (Salem 2007).

In Manuela’s narrative, I have explored how the ‘medicalization’ perspective enabled the understanding of childbirth as a universal and physiological event, which in the course of time has been turned into a medical event, or in other words, have become ‘medicalized’. Jessica’s narrative is an example of how this understanding has motivated a demand for a ‘de-medicalization’ of childbirth. If physiology has become dominated by medicine, it is likewise possible to return it back to the state of being ‘non-medical’. I contend that it is in the understanding of the body - as a natural non-historical entity, and the event of childbirth – as a physiological event – that ‘medicalization’ and ‘naturalization’ find common grounds: In the quest to regain the ‘natural’ body or the physiological event, ‘de-medicalization’ becomes ‘naturalization’.

I argue that the same rationale can be observed in the notion of ‘humanization’ in Brazil. By sharing the same ideal of respect and protection of the physiological birth and its natural course, the notions of ‘humanization’ and ‘naturalization’ overlap. I therefore suggest

that the notion of ‘humanization’ in Brazil appropriates not only an attack on the ‘medicalization’ of childbirth, which is also central to the ‘natural’ childbirth movement, but its whole rhetoric in pursuit of an authentic natural physiology of birth.

5.3 End: Pain as Embodied Power

When leaving home after labor started, Jessica had brought along a plastic, just cleaned with alcohol by her in-laws, to wrap the mattress where she would give birth. In hospitals, the mattresses are wrapped in a thick plastic that is washable. In her narrative, Jessica did not mention the plastic again. The plastic however, draws attention to some practical elements that set the stage for a home ‘humanized’ birth.

Traditionally in hospitals in Brazil, women labor inside an obstetric center. There is a room for laboring women where each woman has her own bed. After the dilation is complete, labor follows in a different room, the birthing room. Women are placed on a high bed, popularly called in Portuguese as “table” (*mesa*). It is actually higher than a regular table, and laboring women have to use a stool to climb on it. In most public hospitals, the birthing room has two or three “tables”, and there are additional rooms for cesarean sections, curettage²¹ and other procedures.

Michel Odent was the coordinator of the maternity hospital in the city of Pithiviers in France in the 1970’s (Salem 2007). He is considered a pioneer for introducing systematical changes in the physical environment for childbirth (Salem 2007). In Pithiviers, women labor and give birth in the same room. All medical equipment and furniture are substituted by house-like furniture, giving place for a low mattress, a bathtub, a fridge with food and drinks, ambient music, and low lights (Salem 2007). The midwife takes the place of the doctor, and women are encouraged to give birth in a position they feel comfortable with, although Odent stresses that the main position chosen by women in Pithiviers is the upright position (Salem

²¹ Medical procedure performed in order to empty the uterus of debris, after a miscarriage, for instance.

2007).

These changes in the physical environmental surrounding childbirth introduced by Odent in Pithiviers can be observed in Jessica's narrative, in my interviews with other women, and on the websites I read, and is clearly associated with the notion of 'humanization'. Ana for instance, focused on some spatial characteristics, when explaining what she understood by the term 'humanization':

I don't know, when people talk about humanized births it comes too much fancy words in my head you know? I think: "People! Stop with that! You know, birth is birth. If you want to have a water birth, a ball, a decorated room, okay." (...) So the humanized birth for me, what comes into my head is: "What are you inventing, I don't know, to charge more those who are paying private, to put a make-up on something that maybe you don't need". (...) Because the people I know that did it, they say: "The hospital room was all decorated, things were made out of wood instead of iron". This is something that for me is a bit of a waste. It doesn't make any difference for me. When birth comes, to be in a pretty place, I don't think that is what makes... it was not that... that humanized the birth for me.

As mentioned before, the bathtub, one of the main changes in Pithiviers, is commonly associated with 'humanized' births. Jessica told me that she had ordered an inflatable pool through an internet site, although it did not arrive in time for her birth, in order to have the possibility of laboring or perhaps giving birth in the water. On the Internet, home births are often illustrated with photos and videos of women laboring in inflatable pools. It seems that along with a shared understanding of childbirth as an authentic physiological event in need for protection from medical dominance, the notion of 'humanization' in Brazil borrows practical features, such as a bathtub, advised by some authors who advocate for a 'natural' childbirths.

The emphasis on the physical surroundings during childbirth, suggested by Odent, are based on an understanding that the setting influences the course of birth (Odent 1984). In his perception, not only medical interventions are capable of disrupting the 'natural' course of the childbirth process, the presence of a male doctor or the bright and intimidating setting of

traditional birthing rooms may contribute to complications and failure of the process (Odent 1984). Odent based his changes in Pithiviers in the premise that the place influences the ‘natural’ physiology of birth (Salem 2007). According to him, a more intimate and house-like setting would contribute to a smoother and less painful childbirth (Salem 2007).

5.3.1 Natural Pain

The following excerpt is the continuation of Jessica’s birth narrative:

So we got there, I met Noemi and the first thing I said, I made a pity face and said: “It is hurting...” She had a big smile from ear to ear: “I know it hurts, but it is your child being born.” So, that gave me a [feeling of]: “Okay, then...” It made me calm, you know? But the pain I had after... As I didn’t have time to rest, it felt, I don’t know, it felt surreal... (...) But it is not a pain of: “Oh my God, please take away my liver, because I have a problem with my liver.” No. Do you understand? It is different. We face it in a different way when we get information. (...) So I asked if could go in the shower. Before that, Noemi said she was going to turn the shower on and I got hold of her and said: “Do you think I will manage?” Because it was really painful. And that was my only fear during pregnancy, of not standing the pain. I was not afraid of, I don’t know, of having hemorrhage, or of placenta abruption, or of the baby not being upside down. I was afraid of the pain. Even knowing that it was not a pain due to disease, or death, or these things. I was really afraid because I’m very sensible.

Following Mattingly’s (2010) claim that the presence and place of a specific event in a narrative expresses its relevance to the plot of one’s story, it seems significant that Jessica recalls the pain she was experiencing in her first sentence at Noemi’s house. Her doula tried to help Jessica to change the focus from the pain itself to the fact Carlos was been born, which seems to have comforted Jessica. Pain is often an issue discussed in Internet groups about childbirth, and it was expressed by most of the women I spoke to.

As noted earlier, Dick-Read and Lamaze approached pain in childbirth as a social construct, that “could be eliminated by inducing the right state of mind in a birthing woman” (Cosslett 1994: 9). Odent’s policy of non-interference by staff or the physical environment during childbirth is based on his claim that if the ‘natural’ physiology of birth is respected, laboring women express a modified level of consciousness (Salem 2007: 64). While Dick-

Read and Lamaze suggested specific training techniques to totally eliminate the pain, Odent and other recent authors advocate for a process of re-discovering ‘instincts’ as an inner feature, seeing every woman as capable of finding a way herself of managing the pain to give birth successfully (Salem 2007). In her narrative, Jessica described herself as facing the pain in a “different” way, facing it not as a consequence of a disease, but as necessity to give birth to her child. She told me:

(...) During the pregnancy, in the last three or four months, I searched the Internet trying to find blogs with texts about the pain. It could be science texts, non-science texts, esoteric, anything that could make me face the pain in a different way. Even today people ask me: “Didn’t it hurt?” And I say: “Oh, it did hurt...” But it is not the same thing that you feel when you had a surgery to remove your appendix, for instance. It is your child that is being born, and the pain means that your uterus is doing its job to bring your child to the world. Do you understand? (...) Today I think if I had worked that [idea] better, if I had understood that by the time [when she gave birth] (...) maybe, I wouldn’t have felt that much pain (...) Maybe I was too afraid. Maybe, with a next child, when I already know how it feels, I would feel less [pain]. Because the pain is also very psychological, it is in our head right?

It seems that by a view of the pain as an intrinsic component of childbirth, and moved by her wish of avoiding medical interventions as for instance the anesthesia, Jessica understood the pain as an inseparable feature that would happen either at the hospital or at home, and searched for ways of handling it.

One of Odent’s main views, proclaimed by advocates of ‘humanized’ birth in Brazil, is his argument about childbirth as fundamental for human secretion of “love hormones” (Odent 2013: 110). “Love hormones” were mentioned in many of the websites I read and were also an issue discussed in the Brazilian documentary cited above. According to Odent, Oxytocin, the main hormone that induces and maintains labor, reaches extremely high levels when the baby is born, responsible for the overwhelming feelings experienced by mothers in relation to their babies at this moment (*ibid.*). For him, this hormone is essential to the bonding between mother and child, and to human’s capability of loving (*ibid.*). However, Oxytocin secretion is

suppressed by Adrenaline secretion or synthetic Oxytocin administration, which according to Odent, is used in almost every hospital birth in the world (Odent 2013: 21-22). Odent claims that 'natural' Oxytocin secretion is a sensible bodily activity, and that stress, fear, bright light, loud noises, interfere with this physiological process. The hospital environment, interventions and staff, induces adrenaline secretion, slowing down the 'natural' birth process that requires the administration of synthetic Oxytocin, which than again suppresses even more 'natural' Oxytocin (Odent 2013: 73). If Odent's claims are considered, in order to be exposed to natural Oxytocin, a woman has to face the pain in childbirth with no drug use.

Odent goes even further in his latest published book, 'Childbirth and the Future of Homo sapiens' (2013). Based on recent research, Odent claims that contemporary childbirth is becoming increasingly difficult. According to him, the continuous use of synthetic Oxytocin in childbirth in the last decades has disrupted the complex hormonal flow of 'natural' Oxytocin, weakening this physiological function (Odent 2013: 22). For Odent, this process "may have far-reaching effects, since Oxytocin is involved in all aspects of our reproductive/sexual life, in socialization, and in all facets in the capacity to love, which might include respect for Mother Earth" (Odent 2013: 22). In other words, in order to preserve the future of human kind, by protecting the hormones that make us capable of loving, women have to subject themselves to non-interventionists births.

For Odent, if given freedom, women 'instinctively' search for alternatives to handle the pain, and often find them in walking freely, warm baths, silence, low lights, and by expelling the baby standing or squatting. All the ambient changes suggested by him are in order to provide a propitious environment, where women can re-discover their 'instincts' (Salem 2007). If the 'natural' birth process is respected, women achieve a mental state that enables them to successfully give birth without the need for any intervention (Salem 2007).

The view that a birthing woman achieve a mental status that could eliminate the pain, as suggested by Dick-Read and Lamaze, or that could enable her to successfully give birth on

her own by finding her 'instincts', as suggested by Odent, has been highly criticized by feminist authors (Cosslett 1994, Martin 2001, Salem 2007, Tornquist 2002). This view of a special mental or subconscious state, that excludes social or cultural components, is criticized by feminist scholars as to identify childbirth, and women as its main doer, with the realm of an unchanging 'nature'. Most of authors of the 'natural childbirth movement', in one way or another, expose a view that "cultural contaminations" (Salem 2007: 65, my translation) may compromise the childbirth process, placing women in a position of not finding their way closer to 'nature' (Cosslett 1994, Martin 2001).

The 'medicalization/de-medicalization' divide developed within the 'medicalization' rationale, appears reconfigured in the 'natural childbirth movement' as a 'culture/nature' divide, where culture represents 'medicalization' and in order to perform a 'natural' birth, the inner 'nature' has to be found. Cosslett (1994), in her book about how women tell their childbirth stories in literature and pregnancy books, reminds us of a recurrent character present in childbirth stories: an image of a woman identified with 'nature', bearer of an inherited inner feature that ought to be re-discovered in order to give birth, which she calls the "primitive woman" (Cosslett 1994: 9-10):

Often identified as 'African', she goes into the bushes on her own, gives birth painlessly and without fuss, and returns immediately to her work in the fields. In various forms, she haunts Western women's birth stories - as an instinctive power in their own bodies, as a learned ideal to be lived up to, as a delusion shattered by experience, or, revised and reversed, as a representative of the primitive pain of childbirth.

According to Cosslett (1994: 3), writers very often reinvent the "primitive woman" as an image of power, which is sometimes taken over by the woman and sometimes handed over to the doctors. The pain, I argue, experienced in the body, emerge as a physical and embodied expression of this power: to undergo the pain is to control the childbirth experience. If there is an authentic physiology of the body, previous to the domination of medicine, as the critical

perspective on ‘medicalization’ support, pain in childbirth belongs to this physiology.

Therefore I argue that in this perspective, in order to achieve ‘de-medicalization’, to preserve the authentic physiology of childbirth, pain is required. To allow doctors to manage the pain is to hand over to them the control of childbirth; to experience it in the body is to express ownership.

5.3.2 Epitome of ‘Humanization’

After describing her reaction when meeting Noemi, Jessica proceeded with her story:

So, she took some time to regulate the water, because it was a gas shower. So, we got in, I got in the shower and Gabriel stayed out and I was holding on him when I had contraction, because when I had contraction I had to lean forward, or I had pain. I think it was because Carlos had his back on my back. So I had to stay with my posture, I don’t now, with my back a little curved. I don’t know. (...) After that Ana Maria came, the nurse. So she said: “Let’s see how many centimeters you are”, because it was already two in the morning. I was having pain, contractions for three, four hours already. So she asked me to sit. It was the worst part ever because I didn’t manage to sit still. I had too much pain. By the time I sat down in the shower I had a contraction and I: “My God in heavens! Why is that?” So she measured the dilation and I was seven centimeters. So, we stayed a little longer in the shower and every time I had a contraction I was screaming. I didn’t care. But it wasn’t a hysterical scream, it was to vocalize the pain, really, it feels that everything overflows. So they asked me to get out of the shower, I don’t know why. I know that I said: “No! Why can’t I stay in the shower?” So they wanted to measure his heart beat too. To listen to it, right? So, after Ana Maria listened to his heart I had another contraction and as I didn’t have anybody else around I held onto her. So, we went to another room, where we had arrived before, and every contraction I had I squatted. They said I couldn’t push. I had to wait the push to come by itself. So, I had, I wanted to push. But it was not that thing that I couldn’t hold. So, I had to keep on trying to not push. It was the worst part; because then, it was not only the pain. I was feeling pain and thinking: “I can not push! I can not push!” Until I really felt that I wanted to push and a lot of liquid came out and I despaired: “My God! What is that” So I said to Noemi: “My God! I pushed without wanting! What happened? She said: “It is the push...” So I was: “Good, now I can push.” So, they brought the ball. Because by then I think Noemi was tired, because she was pregnant. So every time I pushed, that I had a contraction I held on her. So, they asked me to be on fours on the Swiss ball. That was good because then I rested my legs a little, because to stand up and squat, I was tiptoeing and that was tiring. So, I think one hour later, Carlos [the baby] was born. Just before he was born I could feel him coming down and they said: “Don’t you want to see?” So, they brought a mirror. I said: “No! I don’t want to see.” I thought I would get overwhelmed, even though I had seen lots of videos of childbirth. So she said: “Use your hand

to touch him”. So I touched his hair. So he was born. On my last contraction I was exhausted you know? Because I didn’t want to eat anything during labor, I only drank water. So, when the last contraction came I was: “It is going to be now.” So I pushed, I pushed too much I think. I think it is because of that I had a little laceration. Maybe if I had waited, because he came out and in, down and up. If I had waited some more minutes, maybe I wouldn’t have had the laceration. But it was very small. So he was born, and Arian [the other nurse] got him and placed him next to me, because he was born and the cord was under my leg, I untangled myself of the cord and got him. The first thing I did was kissing his little head and his little foot; because, I don’t know, while I was pregnant, I felt him kicking, kicking my back and those feet passing by. So, after the cord stopped pulsing, my boyfriend cut the cord. (...) After he cut the cord they asked me, because I was sitting with them [with Gabriel and Carlos]... They asked me to squat again, to kneel down, and to see if the placenta would come out, because it was not coming out. So I leaned back, and pushed a little and it was born too. So we saw the placenta and it was nothing wrong, it had all the pieces. It was born as a whole. So we kept it. It is frozen.

In this thesis, I have applied Foucault’s theory of power that sees medicine as a productive force. In addition, I have followed some feminist writers as Kukla and Duden in the rejection of the “unchanging natural body” (Kukla 2005: 218) imprinted by culture, arguing for a view of the body as a physical reality, historically produced alongside the development of medicine. In the same manner, I have criticized the assumption that there is an ahistorical physiology of birth that can be restored outside medical ways. As such, I endorse Kukla’s argument that contemporary maternal bodies and the care for it in theory and practice were established during the Enlightenment, and that the conceptualization of maternal bodies is accountable for formation - materially and morally - of humanity (Kukla 2005: 219). Following this line of thoughts, ‘medicalization’ and ‘naturalization’ of childbirth are mutually dependent, rooted in the same view of women as the producer of humanity, and in which standards are demanded to control reproduction. It is in this view that women’s bodies are capable of perfecting or destroying their babies, brought from the Enlightenment, that both ‘medicalization’ and ‘naturalization’ emerge. According to Kukla, although recent technologies have influenced the way maternal bodies are cared for, the anxieties and tensions around these bodies are deeply modern rather than post-modern (Kukla 2005: 218-

219):

We make the cut between so-called 'natural' childbirth and its complement ('unnatural' childbirth? 'artificial' childbirth?) as we did two centuries ago, on the basis of whether the skin of the maternal body is penetrated or punctured by an alien instrument. Massages and herbs are somehow deemed 'natural' whereas knives, needles, and forceps are not, and, without any particular grounding in empirical evidence concerning health outcomes, we continue to valorize the mother who proves her immaculate maternal status by completing childbirth without such interventions (even as, at the same time, we mark many maternal bodies as too riddled with risk - too old, too slow to dilate, too fat, too early, too late - to have the right to even attempt such a 'natural' birth).

Following Kukla, I argue that in Brazil, births as Jessica's are taken as epitomes of 'humanized' births. I further contend that the very notion of 'humanized' births as the ultimate good in the way childbirth should be conducted, reflect our modern - and not post-modern - anxieties: We value childbirth accomplished without specific interventions, where the skin of the mother is kept intact and protected from anesthetics and episiotomies, as the golden standard to be achieved. Interventions such as monitoring dilation, shower and baths, massages, Swiss ball, singing, dancing, walking are taken as 'natural' and accepted within the notion of 'humanization'.

Jessica did not submit herself to a cesarean section, to an epidural or even local anesthesia, nor to an episiotomy. However, she was told when to stay or to leave the shower, to see and touch the baby's head, when to push or not, and when was the 'right' moment to cut the cord after it had stopped pulsing. During pregnancy she submitted herself to prenatal care examinations, screenings and ultrasounds. I argue that the view that we can choose between 'medicalized' or 'natural' ways of birth is a mythical and problematic one, because both are based in an urge to police women's accountability in the production of humanity. In western societies we choose some specific events to mark childbirth as 'medical' or 'natural', based on whether the vagina skin is cut by a doctor's scissor or is left to tear on its own, or on whether we can keep our placentas in our freezers or it is thrown in a hospital's hamper.

I suggest that our portrayal of ‘humanization’ and its ‘natural’ ways as a standard to be achieved is controversial by two main reasons: a) It endorses the divides established by the ‘medicalization’ notion - which undervalues the productive features of medicine and emphasizes ‘de-medicalization’ - producing skepticism rather than promoting women’s dignity; b) it excludes those who are not able to meet the standard. The first reason I will discuss in the following and last section of this chapter. The second reason is the subject of the next chapter.

5.3.3. *‘Humanization’ Distrust*

I shortly mentioned Denise in Chapter Three, when discussing her impressions about reasons for the rise in cesarean sections in Brazil. Denise have lived in Rio de Janeiro and mentioned that some of her friends had had ‘humanized’ births in Birth Centers²². Similar to the other examples I have outlined, Denise also associated ‘humanized’ birth with water births. In addition, she expressed the association of ‘humanized’ birth with a ‘natural’ birth that represented for her less technology and structure and less resources. Denise also associated ‘natural’ births with giving birth in a squatting position. It seems that for Denise, squatting is a practice inherent of indigenous Brazilians, a practice they perform for daily activities, which enables them to give birth in this position. The view that indigenous Brazilian women giving birth in a squatting position can be a model that all pregnant women could learn was published and republished several times in a book authored by the doctor Moyses Paciornik in Brazil (Tornquist 2002). Denise said:

(...) For me, it [humanized birth] is the closest to the natural. It would be without structure, with not so many equipments, like... not much resources right? I have friends that had a humanized birth in birth

²² Birth centers are private or public initiatives, usually driven by nurse-midwives, with a purpose of conducting childbirth with fewer interventions, using ‘alternative’ procedures that differ from the standard ‘medical’ way. Although there are few of them in Brazil, they exist in some Brazilian cities, but not in Curitiba, at least not when I was doing my fieldwork.

centers in Rio [Rio de Janeiro]. In Rio, they have those birth centers. Then you choose if you want in the bathtub, or squatting. You choose. But I think the mother, during the pregnancy, she must to prepare for that. (...) Because today, our daily activities, they don't provide us with that. To have a baby squatting, you need to have had a physical training that assists you to squat. Because the natives do so, but they are there all the time, squatting and washing clothes... They use different positions their whole life. We, I feel our muscles don't function anymore: The butt, the thighs. And suddenly you want to have a humanized birth? I worry about these new trends, you know? Because it is different if you are prepared, even before you get pregnant. If not, you can put yourself in a difficult situation. But, I have friends that had in the tub, which at that time seemed to be in fashion.

In Chapter Four, I have pursued an approach beyond the 'medicalization' notion, arguing that the understanding of power by scholars that embrace this perspective is problematic, as it fails to recognize the productive character of medicine on individual's lives. Lupton (1997) argues that in their efforts to denounce the oppressive power of medicine, the proponents of the 'medicalization' critique tend to undervalue the ambivalent feelings and opinions that individuals have in relation to medicine, or the ways some "willingly participate in the medical dominance and may indeed seek medicalization" (Lupton 1997: 98). I therefore argue that the embracement of 'humanization' as a means of dealing with the way childbirth is conducted in Brazil is equally controversial. In their concern to free women from a 'medicalized' health care and childbirth in Brazil, feminism "have often not realized how profoundly women's opposition to the medical establishment is informed by 'natural' childbirth rhetoric" (Cosslett 1994: 2). While 'humanization' sets the stage to restore women's dignity, it entails respect only towards a predefined will to avoid 'medicalization' and acceptance of 'natural' ways. By endorsing the 'medicalization' critique, feminism tend to neglect the backfire of the fusion between 'humanized' and 'natural' practices, as for instance the so criticized identification of women giving birth with nature. In addition, while to some, as for instance Jessica, achieving more 'natural' ways was eagerly pursued, to many others, 'de-medicalization' is viewed with suspicion. In the above excerpt, Denise expressed a mistrust of applying the 'natural indigenous' way to every woman. Melina is another

example:

The humanized birth that it is talked about is that one I'm really afraid of... because it is not in a hospital that they do it. I think medicine have advanced. And because it has advanced you don't have to hide, or stay at home to have a child. Risking your life, and your child's life. The life of your child depends on you. So both of you have to be safe. So, I think medicine developed, technology followed and that went to an awareness of the need for intensive care for the baby and for the mother at the same place. So many were lost because we didn't have that [in the past]. So, I think today, this mode of birth is kind of imprudent. More than choosing between a cesarean and a natural birth you are denying care, for you and for you child. I think this era has passed. I cannot understand why it's coming back.

Although, as Jessica and other women I interviewed pointed out to me, the efforts to 'humanize' childbirth are based on a pursuit for women's dignity - where hospital births and even cesarean sections can be 'humanized' - I argue that this notion may have some disadvantages, because it lifts up 'natural' childbirths as the golden standard. While all birth modes can be 'humanized', it seems that it is the homelike, water, free of drugs childbirth that is valued as the flawless model. It is in the elevation of the 'natural' childbirth as an emblem of 'humanization' that 'medicalization' comes in through the back door. As noted by Kukla (2005: 223), "an authentic choice against 'nature' is simply not an option for mothers in the moral ontology of the 'natural' childbirth". For a large number of women in Brazil, to 'de-medicalize' and 'naturalize' childbirth is too high a price to pay to achieve 'humanization' in a country where cesarean sections are the norm. Thus, a surgical birth takes the shape of a plausible choice.

CHAPTER SIX: THE NORMAL BIRTH NARRATIVE - REALITY IN PRACTICE

I've never wanted a normal birth. Normal birth for me is for animals. It's abnormal birth. I don't know, I think it's too risky.

Maria, who had a cesarean section

When I arrived in Brazil for fieldwork, I asked a former colleague if she knew any women that had given birth not long ago that I could interview. She introduced me to Alice. Alice worked for my colleague's neighbor as a maid. I contacted her by phone and she agreed with the interview, and I visited her at her house on a Saturday morning.

Alice lived in a small house, surrounded by a low fence. There was a construction site behind her house, inside the fence: bricks, cement and tools all around. A man opened the gate for me and led me to the back of the house, where Alice was waiting for me, her son Noah in her arms. He was around seven, eight months old. We came in through the kitchen and went through the next door that leads to the living room. In the living room, there were two couches, one facing the other. Alice pointed to one of the couches for me to sit, and sat down in front of me on the other one. Noah was placed to play with some toys on the floor between us. The television was on.

6.1 Beginning, Middle and End

Alice started telling me that her pregnancy with Noah was not her first pregnancy. She told me that she tried for ten years to get pregnant, even undergoing treatment for infertility in a public hospital. As her menstruation was always late because of the treatment, Alice didn't know she was pregnant until she gave birth to a premature baby. The baby stayed for nearly a month in an intensive care unit, but did not survive. After that, Alice got pregnant with Noah. She told me:

So Noah's pregnancy was more complicated. Because I was trying to get pregnant, expectant, I didn't know if it would be easy or not. But after nine months I was pregnant again. But then I was scared to

death of losing it. Since the beginning I had cramps, cramps, cramps... and always that fear of losing it. But it was going and going. I had four urinary infections during the pregnancy. And it was because of that that I lost the other one. So I was very nervous. Around thirty-four weeks I had high blood pressure. I couldn't work. I had to stop working. So I stayed at home feeling uncomfortable because of the high pressure. I stayed at home a month, a little more than a month, and suddenly, here it is my little boy.

After she had finished talking, Alice showed me some pictures of Noah as a newborn. Some of these pictures were framed, and placed on a shelf in the living room.

Alice's narrative is very different from Manuela's or Jessica's. While Manuela and Jessica had long stories that I could just listen to, nodding once in a while, or making notes to clarify at the end, Alice's story was very short. After showing me the pictures, she looked at me not knowing what to say in addition. Her story was finished. What came after the above excerpt are answers to my questions. Despite being very short, Alice's birth narrative follows the same characteristics observed in Manuela or Jessica's stories, as described by Mattingly (2011) about narrative theory. Alice's narrative has a beginning, middle and an end, and it is structured to produce a whole that makes sense (Mattingly 2011: 122). It seems that her story has a very clear plot: It exposes the transformation (Mattingly 2011: 131) from a state of infertility to a state of having a child. Also, her narrative did not end when she stopped talking. Alice finished with the pictures, framing her happy ending under the spotlight.

In Alice's narrative I noticed that the event of birth in itself was not present at all. The moment when the baby was expelled from the mother's body was left out. There is the pregnancy and "suddenly" the baby is there. She went from the end of her pregnancy to pictures of her newborn baby and herself as a mother. Alice's narrative was not an exception by being short or excluding the event of birth. I observed that women with lower incomes I interviewed, as Alice for instance, had much shorter descriptions of the birth in itself, sometimes not mentioning it at all.

So far, I have been referring to the exit of the baby from the mother's body through the vagina as 'vaginal birth'. But this is a technical term. Women in Brazil refer to it as 'normal

birth' (*parto normal*). Resorting to some numbers I have described before, if in Brazil the majority of births in the private system happen through cesarean sections, 'normal' birth is found in the public system. Also, most of the women giving birth in the public system have lower incomes. Around 70% of women that give birth through SUS in Brazil have the baby vaginally (Diniz and Chacham 2004). In the public system therefore, 'normal' birth remains the norm and is experienced by the majority of women with lower economic status. In this chapter I will explore Alice's and other women's experiences of a 'normal' birth by comparing their stories with a booklet published by the Brazilian government.

6.1.1 Pregnancy booklet

One of the public health strategies the government has been using for many years in Brazil is the publication and distribution of 'pregnancy booklets'. The Ministry of Health has just launched a new version in 2015. The booklets are distributed to all pregnant women during prenatal care, especially in the public system. It contains short and clear information about fetal development, prenatal exams and vaccines, childbirth, post-partum, sex during pregnancy, breastfeeding and family planning. It also provides advices and tips for healthy eating, exercising and sleeping. The booklet also has information about civil rights, for instance maternity leave and phone numbers to call in case of emergency, violence or abuse. The booklet also contains space for future mothers and father to write their own impressions and questions, and for the health professionals to write during each prenatal appointment, vaccines, exams and medical history, as well as charts for weight gain and uterus growth.

In the following sections I will compare the information provided by the booklet in relation to what women described to me as experienced in practice, focusing on the part of the booklet about childbirth. In addition, I will parallel the reverberations of the 'humanization' notion applied in public hospitals, with objective practices described by Alice and other women I talked to in their stories about 'normal' births. I will analyze how ideas

and views of ‘naturalization’ manifest themselves in the reality women experience in public hospitals in the context of the movement for ‘humanization’ of prenatal care and childbirth implemented by the Brazilian Ministry of Health in response to high cesarean section rates and child maternal mortality.

6.2 Normal Birth: Practices that Frame

When I questioned Alice about ‘humanization’, she said:

Me: Have you heard of humanized births?

She: Oh yes, yes! It is always on the TV. It’s Gisele Bündchen’s²³ one...

Me: What do you think it is?

She: It is the one you don’t have any help right? [It is] the most natural possible. With support from the husband, and the family...

Me: What do you think of that?

She: I don’t know. All cases are different. In my case, as I had high blood pressure, I had to be in the hospital right? I think it depends a lot on your prenatal [follow-ups] right? If there are good conditions, I think it’s good.

Me: Could you have had a humanized birth?

She: I don’t think so, with that condition of high blood pressure, no.

From Alice’s words it can be inferred that, as many others, she also associates ‘humanization’ with home births, natural births and no interventions. The top model Gisele Bündchen had two home births. In addition, Alice explained that her own childbirth was not ‘humanized’ because it happened in the hospital due to her high blood pressure. Along our interview, Alice referred to her childbirth mode as “normal birth” (*parto normal*). Alice’s description of ‘humanized’ births such as Gisele Bündchen’s one, shows on television, while portraying her own birth as ‘normal’, provides a coherent image for my arguments in this chapter. Although ‘humanization’ materialized as a popular notion through governmental policies and campaigns, in practice, the notion seems to be more attainable to those who do

²³ Gisele Bündchen is a famous and popular Brazilian top model

not rely on the public system to give birth and have higher economic status. I noticed that Carla and Paola, both with very low incomes, were the only ones answering that they had never heard of ‘humanization’.

Adriana, the only doctor I interviewed, also expressed a view that ‘humanized’ births do not happen in the public system for lower income women. She worked in both public and private hospitals. In Adriana’s opinion, ‘humanized’ births only happen in private hospitals, where women are allowed some options. Adriana told me that in public hospitals, ‘humanization’ is translated into some recommendations the hospital staff have to follow, that according to her, in some situations do not respect women’s will. She said:

The humanized birth is having a birth the way you want. It is having the option of having analgesia if you want or not. It is when one doesn’t have to go through embarrassing things in front of the others. It is... it is something idealized that doesn’t really happen here [in the public hospital she works]. It is the kind of birth that happens on Virgin Mary Hospital [the private hospital she works]. You choose what you want, how you want it, where you want it, and having someone able to take care of your labor and delivery. That’s what I think is humanized birth. The humanized birth which is recommended here [in Curitiba] is a birth where women don’t need to do tricotomia²⁴, they don’t need to do enema, bowel cleansing... this, I don’t think this is humanization! It doesn’t make sense, even for the patients, to evacuate in front of the others; it may be an uncomfortable situation for her. I think we should have... And tricotomia is your own choice; if you want to do you can, if you don’t want you don’t have to... In the humanized also, you don’t say yes or no to analgesia. But it is better if it’s done without analgesia. (...) Those are the recommendations we get. (...) Some things I end up not agreeing with. I think people should be given the right to choose what they want.

Both Alice’s and Adriana’s opinions exemplifies the clash between theory and practice of the ‘humanization’ notion, also discussed previously. Alice’s childbirth was not ‘humanized’ but ‘normal’. In order to describe what it means in practical terms to have a ‘normal’ birth in Brazil I will go back to Alice’s narrative and highlight some features that will guide the

²⁴ ‘Tricotomia’ is the technical word in Portuguese for removal of hair, in this case, pubic hair. The translation of ‘tricotomia’ to English would be ‘trichotomy’, however, this word does not carry the same meaning in English.

following discussion. Alice told me:

My first birth I think it went so easy, because I got there [in the hospital] and just got [the baby]. So with Noah, I got there five centimeters dilated and I stayed... I got there in the morning and I stayed until five [in the afternoon] and it hadn't passed five [centimeters]. So they gave me the serum [synthetic oxytocin]. That serum is... the worst thing is to get that serum. It is a terrible pain. It feels that it comes all the way here [shows her legs]. (...) So by the time I went to the table, to get him because I had the dilation, he was coming back and forth... He wouldn't come out. Because he was big and I... the first birth is always harder right? (...)

Me: How big was he when he was born?

She: Three kilos, five hundred and forty [grams]. So I stayed around two hours on the table, trying to get him. (...) This time I felt it was much harder than my first time because the serum gives you more pain, and because of his [Noah's] size. I suffered much more; also with the stitches. I got many stitches. I felt all of them as if I hadn't had anesthesia. (...) The recovering was much harder because on the first time I didn't get any stitches. I don't know what to tell you. I suffered a lot.

From the above excerpt, some practicalities of Alice's 'normal' birth can be observed. The features I will explore in the following, drawn from this first part of Alice's interview, are: The hospital, the serum, the stitches and the table.

6.2.1 Hospital

The most visible feature, which I will discuss first, is that Alice gave birth in a hospital. Before the interview, she had already mentioned to me that her baby was born on St. Martha's Hospital. Jessica also mentioned this hospital. It was the one Jessica was assigned to, and according to her, known on the Internet and in media by its 'non-humanized' practices, while St. Phoebe's Hospital is known as 'humanized'.

It seems that for Alice, her birth was not 'humanized' because it happened in the hospital. She doesn't seem to associate it with the fact that happened in that specific hospital, or with the specific practices this hospital follows. From the women I talked to that experienced vaginal births, Joyce, Katia, Paola and Carla experienced childbirth in St. Phoebe's Hospital, and only Alice in St. Martha's. None of them have described their births

as ‘humanized’.

Katia, who I have not yet mentioned, had a daughter, Rafaela, a little over one year old when we met. She told me that Rafaela was being submitted to some exams to investigate delayed development. Katia believed that it was related to her birth. When I asked if she had already heard of ‘humanized’ births she told me:

Actually, I saw that in St. Phoebe, they do this humanized birth. Which is squatting, because it is better if you squat. There are different positions you can do. Or, it is in the bathtub. Actually, I was thinking in doing in the bathtub, but I saw my birth was too hard, a harder childbirth, so I ended up not doing it. So it was on the table.

Me: Did you ask for it or did they offer you? How was it?

She: Actually, I knew already because on the day we visited the hospital we did a course, so he [the father] could participate [of the birth]. So, I saw the different methods they do right? But I wasn’t very interested in doing it.

It seems that Katia, as many others, also associated ‘humanization’ to childbirth in the bathtub or squatting. For her, the birth she experienced was not ‘humanized’ because it was on the table, and not squatting or in the bathtub. Katia told me that she had expected childbirth to be much faster, and experienced her thirteen hours labor as too long. In addition, Rafaela was born a little over three and a half kilos and Katia was thirty-one years old when her daughter was born, and in Katia’s view Rafaela was too big and she was too old to give birth. It seems that all these aspects contributed to an experience of labor and childbirth that was described by Katia with the words “difficult” and “suffered”, and therefore, not ‘humanized’. Katia associated the “complications” she described in her childbirth experience to Rafaela’s developmental delay.

Using Katia and others as examples, I follow Kukla’s (2005) argument presented in the previous chapter, that we tend to elevate ‘natural’ ways as somehow a more valuable achievement, and at the same time, many mother’s bodies are marked as too risky to attempt a ‘natural’ birth. Most women I interviewed presented me with reasons for why they births

could not have been ‘humanized’ or why they did not even try vaginal births. Katia for instance, expressed that her childbirth was too hard to be done squatting or in the bathtub. Another example was Alice, mentioning that the childbirth she experienced was not ‘humanized’ because it happened in a hospital due to her high blood pressure. Both Katia and Alice portrayed their childbirth as “suffering” because the baby was “too big”, yet both babies weighed a little over three kilos.

I argue that the association with ‘natural’ and non-interventionist ways, in a setting where risk is increasingly being displayed, it is one of the means whereby ‘humanization’ becomes achievable to only few. While ‘naturalization’ and ‘medicalization’ appear to oppose to each other, they are both sides of the same coin (Kukla 2005: 223), produced by the same view of an authentic biology and physiology. It is in the same conceptual framework, in which medicine has the power to produce what is ‘normal’ or ‘abnormal’ (Foucault 1994), that the ‘natural’ and ‘medical’ emerge. It is medicine that gives the standard to define when physiology is allowed to work on its own, and in the setting of this research, it appears that it does not happen very often.

The use of showers to alleviate the pain and promote the progress of the childbirth process is a practical feature highly recommended by the government (Brazilian Ministry of Health 2014). In all birth stories I heard of ‘normal’ births in the public system, the woman have used the shower during labor or she was encouraged to do so. The bathtub, also very much recommended in ‘humanization’ documents, was described only in the stories from St. Phoebe’s Hospital. Even so, none of the women I interview described experiencing the bathtub, because as the hospital is equipped with only one, it always happened to be used by another woman.

In the government's booklet²⁵ page showed below (*Figure 1*), on page 19, on the second column, in the headline it can be read: "What you can do to further your labor". One of the measures suggested is showers and baths as an "excellent method to alleviate the pain". Under the headline it is written: "You can change position, searching for comfort at each moment: Seating, laying on your side, kneeling, squatting, on the ball or on the stool, on fours, standing or walking. This positions may alleviate the pain". Under the written information there is a picture of a laboring woman receiving massage done by another woman. Bellow the picture it can be read: "Some positions and massages help to alleviate the pain. Try it out!"

Trabalho de parto

Algumas coisas que você deve saber para ter um bom parto:

Você tem direito a um ambiente sossegado, privativo, arejado, sem ruídos, só para você e seu acompanhante, durante o trabalho de parto e o parto. É fundamental que você seja apoiada por pessoas que lhe tragam ânimo e confiança!

Existem vários procedimentos que **não** devem ser realizados de rotina, mas apenas em algumas situações, como, por exemplo:

- **Lavagem intestinal** – é desagradável e desnecessária; durante o trabalho de parto você esvaziará seu intestino naturalmente.
- **Raspagem dos pelos íntimos** – não é preciso fazer; nem em casa, nem quando chegar à maternidade. Seus pelos são uma proteção natural para a vagina.
- **Romper a bolsa das águas** – o rompimento artificial da bolsa aumenta os riscos de infecção e problemas com o cordão umbilical do bebê.
- **Soro com ocitocina** – torna as contrações mais incômodas e dificulta sua movimentação.
- **Episiotomia** – é um pique na vagina; pode causar dor e desconforto após o parto e aumentar os riscos de infecção.

O que você pode fazer para favorecer seu parto

Você pode mudar de posição, buscando maior conforto em cada momento: sentada, deitada de lado, ajoelhada, de cócoras, sentada na bola ou no banquinho, de quatro, de pé e caminhando. Estas posições podem aliviar a dor.

- **Caminhar e movimentar-se** pode diminuir o tempo do parto.
- **Tomar banho de chuveiro ou banheira** é um ótimo método para aliviar a dor.
- **Beber água e comer alimentos leves** dão mais força e energia para você e seu bebê.
- **Respirar profundamente**, no ritmo da contração, facilita a abertura e a saída do bebê.



Algumas posições e massagens ajudam a aliviar a dor. Experimente!

Figure 1. Page 19 about labor and childbirth. All information written in Portuguese is discussed along the chapter.

In addition to showers and baths, walking is very much recommended in the government's booklet (*Figure 1*). The other advices provided under the same headline are: To drink water

²⁵ Brazilian Ministry of Health (2014), my translation

and eat light food in order to give energy to the woman and the baby; and to breathe deeply, in order to facilitate the opening process and the exit of the baby. In all the stories I heard of ‘normal’ births in public hospitals, women could walk and drink water. Eating however was not allowed to most of them. Joyce said:

I could walk. They wanted me to sit on the ball, they wanted me to walk, and they wanted me to go I don’t know where... the only place where I felt comfortable, where I didn’t feel that much pain was under the shower.

The ball mentioned by Joyce, which was also described by Jessica in her story, is also recommended in the booklet. On the next page, page 20, in the booklet (*Figure 2*) there is a picture of a woman sitting on a ball. Under the picture it can be read: “The ball helps the baby to engage better, to dilate faster and to alleviate the pain. Under the shower it can be even better”. Katia also mentioned using the ball in St. Phoebe’s Hospital. Alice did not described having used it, or seen it in St. Martha’s. Alice, similar to Joyce, also commented that she was not allowed to eat during labor:

I could walk around inside that room. But I couldn’t eat. I stayed the whole day without eating.

Me: what about water?

She: Water yes. Because I had done the enema, so they don’t allow you to eat. I was really hungry because I had not eating since morning. He was born around six in the afternoon, but the pain had started before dawn...

The material I read about ‘humanization’ in Brazil, as for instance some articles and governmental documents, often support the use of ‘evidence based medicine’. The various websites advocating for humanization of birth in Brazil I looked at also refer to the same expression. It seems significant to the notion of ‘humanization’ that the practices promoted are based on research. WHO features as the main institution providing guidelines for practice in many documents issued by the Brazilian government. In the manual “Care in Normal Birth: a Practical Guide”, published by WHO in 1996, some of the advices provided by the

Brazilian booklet that is discussed here can be found.

In WHO's manual showers, bathtubs and other non-pharmacological methods are mentioned for handling the pain in 'normal' birth (WHO 1996: 14). WHO recommends showers, immersion in water and other methods based on the premise that these practices are harmless and commonly used in many countries, but mentions that research about these specific practices are rare (WHO 1996: 14). However, WHO highlights that the widespread comfort described by women in the use of these practices is perhaps due to the attention and personal support that often follows it, and that personal support should be the focus in the care for laboring women (WHO 1996: 14). Based on WHO's suggestion, it is perhaps noteworthy to evaluate if showers, bathtubs and balls (the last one not mentioned on this specific WHO manual) remain effective in the Brazilian setting. Maternity hospitals in Brazil are often understaffed, and most of the women I interviewed recalled being left alone, or supported only by their husbands.²⁶

Concerning food ingestion, WHO recommends no interference in women's preferences and wishes during labor (WHO 1996: 10). However, it is highlighted that food intake is so variable and culturally influenced in different settings around the world, that the main advice presented in the manual is fluid and light food ingestion (WHO 1996: 10). In addition, WHO stresses that there is a lack of research also on this issue, and that many questions remain unanswered (WHO 1996: 10). The recommendation of fluids and light food intake is preferred in order to avoid common complications in longer labors, such as dehydration. The bulk of research that WHO base their recommendations on, have shown complications of routine administration of intravenous fluids during labor, the main practice in settings where no ingestion is allowed (WHO 1996: 9). Therefore, WHO does not recommend this practice. The free food intake is also recommended based on a second bulk of papers that have

²⁶ It has been a strong social and political pressure to allow the presence of a companion to women in labor in hospitals. This issue will be discussed later in this chapter.

demonstrated that restriction of oral intake do not guarantee reduced stomach content, in case general anesthesia is necessary (WHO 1996: 9). The Brazilian booklet follows WHO's recommendations for ingestions of fluids and light meals. However it is interesting to note, that this advice is given to pregnant women in Brazil where most hospitals do not allow them to eat during labor. One may also question the effects of the information provided to women, in producing expectations that will not be fulfilled.

According to WHO, low risk births can happen in hospitals, birth centers or at home (WHO 1996: 12). As mentioned before, most of births in Brazil happen in hospitals (Leal *et al.* 2014a). Birth centers are uncommon. Home births happen in remote areas of the country, or as a minority in big cities, always paid as an out-of-pocket payment, since there is no option for home births neither in the public nor private systems. These circumstances make home births an option for those who can afford it.

Joyce, Jessica and Alice searched for alternatives during pregnancy, trying to avoid giving birth at the public hospital. Joyce told me that she could not afford a private 'normal' birth, but the home birth was affordable. She had already made all the arrangements for it, only it did not happen because at the end of her pregnancy she developed high blood sugar and was advised by the Butterfly Group to have the baby at the hospital. Jessica also got information about costs of a private 'normal' birth, which was also not affordable to her.

Alice also searched for private care during her pregnancy. She said:

I went to one appointment with a private doctor. He gave me an estimate to give birth in the hospital he works. He didn't give me an estimate for a normal birth; he already gave me the one for a cesarean. So, it means he wouldn't do the normal birth.

Some researchers in Brazil have demonstrated the use of technology by lower income groups through cheaper and affordable private services in order to overcome socio-economic inequalities experienced in the public medical system (Béhague *et al.* 2002). Women from

lower incomes would search for private cesarean sections in order to avoid giving birth in the public hospital (Béhague *et al.* 2002). In Alice's story, she wanted to give birth vaginally because of her previous experience of a fast and easy premature birth. She decided then to face the normal birth through the public system. Alice did not arrive at home birth as an option, perhaps because she did not have access to the same information sources Joyce and Jessica had. For Alice, her childbirth experience had to happen in the hospital because of her high blood pressure. For most women in Brazil, birth happens in the hospital because that is the only option. It is interesting to note as well that there is no mention of births at home or in birth centers in the Brazilian booklet.

6.2.2 'Serum'

A second practical feature of Alice's normal birth is the use of synthetic Oxytocin, which is popularly called in Brazil as "serum" (*soro*). In Brazil, a recent survey has shown a use of synthetic Oxytocin in nearly 50% of low risk 'normal' births (Leal *et al.* 2014a). As Alice mentioned its use, I asked if she could explain more about it and she told me:

They told me they were going to give me a medicine to help to dilate. They didn't say what it was, nothing. They put that serum in your vein and you keep on taking it. That thing hurries up [the contractions] very fast. They put me on the serum at five and in half an hour I was fully dilated you know? But it increases very, very, very much the pain.

Me: What would you prefer?

She: Oh, I would prefer like the first one [the preterm childbirth she had], natural... (...) The pain is much less when you don't have the serum. You feel like a menstrual cramp, harder, but you can hold it. But after [with the serum], I don't know, it feels it's going to your head! (...) It is horrible.

Among the women I interviewed that experienced childbirth at St Phoebe's Hospital, Katia also described having used the "serum". According to her, the use was initiated after she was placed on the "table":

After some time I couldn't get up anymore, not even to go to the shower, because I had too much pain. So the doctor broke my water. It was in the middle of the night. So she asked me to push, to see if it would go natural. But there was no way. I pushed and pushed, and nothing. So they put me on the table to force it. Then they put in the serum.

Me: They didn't use it before?

She: No. They didn't. It was on the spot [when she was placed on the table]. Then it went very fast.

In the first column of the booklet (*Figure 1*), on page 19 in the second headline written in purple, it can be read: "There are several procedures that should **not** be performed as routine, but only in some situations". The contraindicated procedures are listed below the headline. The fourth one in the list is synthetic Oxytocin use. According to the booklet, synthetic Oxytocin makes contractions more uncomfortable and moving around more difficult.

The third procedure on the list of non-recommended procedures in the booklet is the artificial rupture of the amniotic sac, which was also described by Katia. According to the booklet, the artificial rupture should not be performed due to increased risk for infections and complications with the umbilical cord. However, in Katia's experience, she believed that the doctor should have artificially broken her water even earlier. As mentioned before, for Katia, the delay in the procedure was associated with the development issues her daughter is having. She said:

My labor was very long. They say it's because of my age... the age, and also a big child. Everything influences the birth (...) and also my family history. My mother, none of them [other women in the family] broke their water without interventions. None. All of them had difficulties. (...)

It was a very long labor. They took it to the last. They say that it [her daughter's condition] can happen with normal [birth] or cesarean [birth], this can happen. (...) Sometimes it lacks oxygenation, I don't know. (...) They could have broken the water before, a little before. It took too long, to break, everything. (...) I was always asking them, the nurses, the first thing, they wouldn't come there to check if everything was okay. Actually, they would take some time to come. So my husband was always asking the doctor: "Don't you think it is time?" She would say: "No, easy. It's not time yet".

According to WHO, early amniotomy - the artificial rupture of membranes - associated with intravenous infusion of Oxytocin is often called "active management of labor" (WHO 1996:

23). This practice was studied and first adopted in Ireland in the 1970's, and presently widely used around the world (WHO 1996: 23). The research described by WHO shows that early amniotomy promotes a reduction in average of 1-2 hours in the duration of labor, although decreased fetal heartbeat can be observed with the practice. Continuous and routinely use of Oxytocin has shown reduction in labor duration in one randomized trial and no reduction in two others, all trials showing no complications in fetal outcome between groups (WHO 1996: 23). In addition WHO describes research reporting increased pain with the use of Oxytocin (WHO 1996: 23). WHO declares that it is not clear if the mentioned practices are beneficial or not. Therefore, their recommendation is that amniotomy and Oxytocin infusion should not be used as a routine, although it can be a resource especially in prolonged labors (WHO 1996: 23). It is advised however, that synthetic Oxytocin can only be used in hospitals under an obstetrician's responsibility and fetal surveillance by electronic monitoring (WHO 1996: 23).

6.2.3 Stitches

Alice described that she got some stitches after giving birth. It seems that Alice was submitted to the last procedure on the government's list, namely episiotomy. In the booklet it can be read: "Episiotomy: It is a small cut on the vagina; it may cause you pain and discomfort after birth and increase the risk for infection".

In South Brazil, where the city of Curitiba is situated, the frequency of episiotomy in vaginal births was around 80% in 2009 (Brazilian Ministry of Health 2009). Recent data has shown a percentage of 60% in the same region (Leal *et al.* 2014a). It is unclear however, if these percentages represent a real decrease in this practice, since the data collected in the first mentioned research included all vaginal births, while in the second, only women from low risk pregnancies were included (Leal *et al.* 2014b). In addition, the methodology for data collection was different, limiting comparisons between the two papers (Leal *et al.* 2014b).

Except Jessica who had her baby outside the hospital, all women I interviewed that had vaginal births described having experienced episiotomies.

Beatriz was the only woman I talked to that had a ‘normal’ birth in a private hospital. Her story was very interesting to listen to. She experienced only a few contractions, and in a period of two hours her baby was born. She told me that she and her doctor had already agreed on a cesarean section, but everything went so fast that the ‘normal’ birth was unavoidable. To my surprise, what started sounding as a very easy birth, ended with episiotomy, forceps²⁷ and fundal pressure (also called the Kristeller maneuver²⁸). Even more surprising is Beatriz’s description of her birth as fast, easy and smooth, in contrast with the traumatic narratives I had heard when those procedures were used. She said:

So it was very smooth because he got there [the doctor] and I told him: “So, are you going to do my cesarean?” And he said: “No, we’re going to do the normal birth because the baby is already here. I’m not going to cut your belly.” I trust him very much. (...) So five past eleven he came [back] and I pushed two times very strong and the nurses pushed [too]. But he [the baby] was very high and he was moving until the last moment, I could feel him moving. He [the doctor] said: “I’m going to monitor the baby and everything will be fine”. (...) So on the third time he called another doctor that came and put all his weight here [shows the belly], I even got a bit bruised here. The baby just showed up and he used the forceps. But he didn’t tell me, so I wouldn’t be nervous. But Renato, my husband, he saw right? He was... frozen! He didn’t even manage to take pictures; he didn’t manage to do anything. But, it [the forceps] helped a lot, because he just adjusted and when he put that thing [the forceps], he [the baby] came out. It was very, very fast. (...)

Me: Did he do the episiotomy? (...)

She: Yes. But I didn’t even manage to count [how many stitches]... Because I asked my sister right, out of curiosity, I asked: “How many stitches?” because he [the doctor] didn’t tell me. Then after I asked my sister to look and she said: “I can only see around three here...” It was the kind that falls out [on its own]. But he [the doctor] only did it to help...

²⁷ Forceps is a surgical instrument consisted of two branches to be positioned around the baby’s head to assist the delivery.

²⁸ Fundal pressure or Kristeller maneuver is a practice of pressuring the top of the uterus, done by a doctor or a nurse while the mother pushes, to squeeze the baby out.

Besides Beatriz, none of the women I talked to mentioned forceps. Katia and Joyce in St. Phoebe's Hospital however, experienced fundal pressure. Joyce gave me a very detailed description of the final moments of her birth. She said:

They saw I was ten centimeters dilated at the same time of another woman [that was also ready to give birth]. She was in labor for twelve hours. [Joyce was in labor for around five hours]. They gave their attention to her. There was only one staff at that time, because it was in the middle of the night. (...) So, I stayed there, suffering, and he [the resident physician] said: "If you fell like pushing, push. But we can not stay here helping you now, because the whole staff is helping that other lady". (...) But he told me to push, but I didn't know how to push, for how long I should push. I was pushing, but I was pushing for too little time. So the baby would start coming out, and then go back... (...) By the time I got to the table, in the birthing room, I had no more strength, not even to breathe properly. So the doctor, the boy's [the resident physician] boss, he was like a horse! He started to push my belly... that maneuver... I don't know the name of that. (...) So the boy that was performing the birth, the resident, he said: "Look Joyce, I will have to cut, you don't have more strength to push". And I: "No... For the love of God, don't cut, I can do it". Then he: "No, it's still a long way to go, he's very high and you're not managing to push..." He [the resident] said that David [the baby] was not even moving with my pushing. So he said: "Okay, so you're going to have to... I'm going to cut and you are going to push, push!" By then, he had already cut. While he was talking to me, he had already cut. I had not even realized. So he said: "Push". And I said: "Okay, let me know when I can push..." "Push now!" So I pushed and he came out.

In Brazil, there is a current debate concerning the Kristeller maneuver. One author argues that the procedure may offer benefits in some situations, if the pressure is performed using only hands and with the woman's consent, in order to avoid unnecessary use of forceps (Cecatti 2014: 34). According to Cecatti, this maneuver should not be listed as completely unnecessary, as classified by the authors in the article of Leal et al. that he criticizes (Cecatti 2014). These authors argue that there is no available evidence of benefits, and potential risks associated with this maneuver to justify the advice to discontinue this practice (Leal *et al.* 2014b). Their argument is consistent with WHO's recommendation. In the manual, WHO states that due to lack of research, this practice is not recommended (WHO 1996). In addition, Leal *et al.* (2014b) argue that the prevalence varying from 30-45% in different Brazilian regions is extremely high, since the data included only low-risk pregnancies,

indicating an unjustified overuse of this maneuver.

WHO classifies forceps as an operative delivery (WHO 1996). In Brazil, the prevalence of forceps use is very low, amounting to 1.4% of all births (Leal *et al.* 2014b). This percentage however, is difficult to evaluate since research in Brazil has demonstrated that the practice has been abandoned due to lack of medical training to perform the procedures and fear of law suits (Leal *et al.* 2014b). WHO states that there is a worldwide increase of operative deliveries in need for additional research, and classifies this practice as frequently used inappropriately (WHO 1996). Neither fundal pressure nor forceps are mentioned in the Brazilian booklet.

Episiotomy is a practice also under attack. Its use varies widely around the world, from as low as 9.4% in Sweden to as high as 100% in Taiwan (Carroli and Mignini 2009: 3). Research has shown that the routine use of episiotomy is not beneficial, and is associated with complications such as increased perineal trauma and healing complications (Carroli and Mignini 2009). WHO recommends that policy for use of episiotomies should be restricted to around 10% in case of signs of fetal distress, insufficient progress of delivery or threatened third-degree tear (WHO 1996: 28). However, WHO further recognizes that these mentioned diagnoses are sometimes difficult to make when birth is happening, especially threatening third-degree tear, which may lead to over-diagnose, and hence a conservative approach is recommended (WHO 1996: 28).

6.2.4 Table

On the following page of the government's booklet (*Figure 2*), page 20, there are four pictures under the headline "birth positions" (*posições de parto*). The first picture shows a laboring woman, being supported by a man. Under the picture it is written: "Finding support in your companion may help you to get strength in the final moment of labor". Underneath there is a picture of a laboring woman, squatting and holding on a support bar: "The squatting

position helps a lot in labor”. There is further a third picture of a laboring woman on one knee: “Squatting, kneeling or on fours can facilitate your birth, try it out. Find a position you feel it’s easier”. The last picture is of a laboring woman sitting on a ball, as already mentioned. In between the four pictures there is a sentence that says: “Think about something that could help you during your labor. For instance, listening to music”. Next to these four pictures, there is a text under a purple headline that says “The birth” (*o parto*). In the last paragraph it is written: “You are accustomed to see women laying down for the birth, but squatting, seating or kneeling are better to ease the exit of the baby: the birth channel is shortened, the vagina opening gets wider, the oxygenation for the baby is greater. Try and find a suitable position for you”.



Figure 02. Page 20, about labor and childbirth. All information written in Portuguese is discussed along the chapter.

As mentioned on the last chapter, in Brazil, most women deliver their babies on a high bed popularly called “table”, in a birthing room. This dorsal position is reported as being adopted in 90% of births in Brazil (Leal *et al.* 2014a). Women are brought to the birthing room after dilation reach ten centimeters, when the second stage of labor is assumed to have started. Alice and all women I interviewed, except Jessica, had their babies on the ‘table’.

According to WHO, research has shown greater advantages of upright positioning in comparison with dorsal or semi-recumbent position (WHO 1996: 27). Vertical or upright position is associated with less discomfort and pain and shorter duration of the second stage of labor (WHO 1996: 27). Recent research has also demonstrated that women giving birth in upright positions have less chances of being submitted to additional interventions and report more satisfaction (Priddis *et al.* 2011). However, WHO states that some disadvantages have been shown, as for instance increased blood loss and increased chances of tearing (WHO 1996: 27). Therefore, the recommendation is to encourage women to adopt positions they feel more comfortable with, avoiding longer periods of laying down on their backs (WHO 1996: 27). However, WHO highlights that a successful experience in an upright position requires also willingness and experience of the caregivers (WHO 1996: 27).

After Alice had mentioned the practices she experienced, I asked her how and when her labor started, hoping that my question would trigger more memories. She told me:

It was in the middle of the night. I started to feel some cramps, and then I started to count. It was happening every ten minutes. It didn’t slow down. But it was too early to go to the hospital right? So I went to the health unit to check my blood pressure and it was high. So I went to the hospital. I got there and I was admitted. Then I did all the procedures, the enema, the shaving, those things they do. Then I stayed there. They sent me to the shower. I laid down, I sat down, I walked a little. They would come once in a while to check the dilation. It didn’t go over five. Then I had to be put on serum. (...)

Me: Did they ask you if you wanted the enema or the shaving?

She: No. This is a hospital procedure for everybody. Last time I didn’t do it because I arrived there almost getting it [the baby].

Me: If you could choose, would you do it or not?

She: I think I wouldn't do that... [Enema] because you're already feeling pain, and that enema gives you even more pain.

Me: How was the room you stayed?

She: It was like a ward, divided with sheets. Then there was other women in the same place; each one of them with their partners. The nurses and doctors were around, but they came only once in a while to check if the dilation was wider, to check blood pressure, these things. My husband stayed with me.

Me: Was he with you?

She: He was. He could have seen the birth, but he didn't want to. (...)

On the list of procedures that should not be performed as a routine, advised in the government's booklet and discussed above, besides artificial rupture of membranes, Oxytocin use, and episiotomy, enema and shaving are also listed. From this last part of Alice's narrative, the practices of shaving and enema will be discussed in the following. Alice also mentioned that her husband was with her during labor, inviting the subject of the presence of companions during childbirth, which I will also discuss.

6.2.5 Enema and Shaving

Enema is a procedure preformed for cleansing of the lower bowel by injection of fluids through the rectum. From the women I talked to, only Alice experienced this practice, which according to her, was performed as a hospital routine. She was also the only one to describe shaving of pubic hair.

During the time I studied medicine and worked as a medical doctor in the city of Curitiba, although I had heard that these practices were routine in the past, I have never seen it happen. Adriana, the doctor I interviewed for instance, mentioned first these two practices (she named the shaving as tricotomia) when explaining the recommendations followed by the hospitals she works at. According to her, shaving and enema are not performed in order to 'humanize' the childbirth process.

According to WHO, both practices have no scientific evidence of benefits, and therefore, should not be performed (WHO 1996: 9). Women usually describe enemas as very

uncomfortable and painful (WHO 1996: 8), following Alice's portrayal of this practice.

WHO however remarks that while most women describe enema as embarrassing, some may ask for it. Adriana confirmed this view, when she criticized the fact that enemas are no longer an option in the hospitals she works.²⁹

In the Brazilian booklet, on page 19, enema and shaving are the firsts two practices listed under the procedures that should not be performed as routine. The first one written is: "Bowel cleansing: It is uncomfortable and unnecessary; during labor you will naturally empty your intestine". The second one is: "Shaving of pubic hair: you don't need to do it; neither at home, or by your arrival at the hospital. Your hair is a natural protection for the vagina". These two are followed by 'artificial rupture of membranes', 'Oxytocin serum' and 'episiotomy', all already discussed.

6.2.6 Companion

Alice mentioned that her husband stayed with her during labor, but did not want to see the delivery. She was alone for around two hours, during the expulsive period. She told me that just after Noah was born, her husband came back and stayed with her all the time. A cousin stayed with her over the night, since male companions were not allowed to stay after eight in the evening.

Since 2005 the law in Brazil ensures the right for a companion during the whole hospital admission (Diniz *et al.* 2014). Although in different ways, all women I interviewed had this right somehow respected. Only Joyce and Paola asked to be alone: Joyce during labor and delivery, and Paola during her cesarean section. In Joyce's case, when she was admitted in the hospital because her water had broke, her contractions had not started yet. She stayed alone until labor spontaneously started, after then her husband was called to come. She recalled:

²⁹ This part of her interview is already mentioned before in this chapter.

When I was seven centimeters [dilated] they called Theo [the husband]. (...) So Theo came. But my husband is really hyper. (...) I was in the shower, squatting, with a pain I had never thought I would feel in my existence, he looked at me and said: “Hi babe, long time no see!” I looked at his face and said: “Go away Theo!” [He said:] “What? But I just came...” [She said:] “No! Go away!” (...) I didn’t want to look at his face. (...). It was a choice, I wanted to stay alone, and it was better for me. Because I felt... it’s ugly to say that, but it’s true... I felt like a dog, when they hide to give birth to pups you know? Nobody can find the dog and when you see it it’s in the closet? Something like that... I didn’t want anybody close to me. The presence of anybody annoyed me. Including the nurse. Even her voice stressed me. So I locked myself in, I closed the bathroom door, she would come, push the door and say: “You can not stay closed in here!” And I: “But I need to stay alone!” She said: “You can stay alone [in here], I will be sleeping over there, but you can not stay alone” [with the door closed].

Joyce told me that at St. Phoebe’s hospital, male partners and siblings are allowed to visit in the afternoon, but similar to St. Martha’s hospital, only female companions can stay over the night, although no beds are available for them, only a chair.

For Paola, the whole social setting seemed to have contributed to her decision. Paola was the only woman I interviewed experiencing a cesarean section in the public system. She told me that in the beginning of her pregnancy, her husband got shot because of gang and drug issues. He was still in an intensive care unit by the time she gave birth. As this was her second pregnancy, she had another child to care for, which was taken care of by her sister when she went to the hospital. In addition, Paola mentioned that even when her first child was born she preferred being alone. Paola recalled feeling ashamed of being naked and giving birth in front of other people. She told me:

My little boy [her first child], he didn’t stay with anybody. (...) So on the day I went [to the hospital] I had to leave him with my sister. (...) So I told her: “Distract him so I can leave”. So I took the bus and went. I had already called my sister-in-law to tell them [to tell the rest of the family she would have to stay for the cesarean section], it was already nine in the morning. And she didn’t even tell the others [the rest of the family]. They found me at the hospital; it was already nine in the evening. They were searching for me. (...) They [people from the hospital] told me they could make a call to someone in my family, to call someone to be with me in the cesarean. I could, but I felt already embarrassed by them [hospital staff]. I said: “No, I don’t want anybody. I prefer to go alone;” because with my first, with my

first boy, my husband wanted to come in to see the birth. I didn't want to.

Me: Why?

She: I don't know. I felt embarrassed. (...) I don't know, it is something weird [the birth]; especially normal [birth], with him [her oldest boy]. (...) [For the cesarean] I only took my clothes of up here, I stayed with my under pants on. So she [nurse] said: "No mom. You have to take everything of." (...) We feel embarrassed because there are a lot of doctors.

Katia seemed to be very satisfied with having her husband accompanying her. She mentioned his participation many times during the interview, and portrayed him as very helpful during her labor process. She said:

It was very good. They [hospital's staff] told me that Juliana [someone from her family] had accepted to stay. But I said: "No. I prefer my husband." I think it's different right? It is different from family, your sister-in-law.

Me: What did he help you with?

She: He helped massaging my back; he helped with the massages. He took me to the shower; he carried me around, because I didn't manage to even walk. He helped me with the walks I had to take in the hall...

According to WHO a range of research studies have shown benefits of continuous empathetic and physical support provided by doulas, midwives or nurses (WHO 1996: 12). The evidence described by WHO shows that there are less interventions, better APGAR scores, more maternal satisfaction and better breastfeeding rates, if women are continuously assisted by a female caregiver during labor and delivery (*ibid.*: 13). Therefore, physical and emotional support is strongly recommended (*ibid.*: 13). WHO seems to draw attention to the significance of doulas for laboring women, since it is underlined that midwives and nurses usually have other technical tasks to perform, that may take away their attention from the woman (*ibid.*: 13). In addition, WHO highlights the importance of privacy and limiting the amount of people in the room (*ibid.*: 13). Paola's case can be taken as an example of this matter, since she mentioned feeling embarrassed of the presence of "too many doctors". It is also highlighted that people in the room accompanying the laboring woman, should be people she trusts, her partner, friend, doula or midwife (*ibid.*: 13).

However, WHO recognizes that ideal situations do not represent the reality of most countries in the world (*ibid.*: 13). As many women I interviewed in Brazil described, the rooms they stayed in had place for more women and their companions. WHO recommends that caregivers should work on a much smaller scale in order to meet women's needs for continuity of care, but recognizes that these are measures that imply costs, thus becoming a political issue (*ibid.*: 13). Their final recommendation is for each country to find suitable solutions to provide women with continuous encouragement during childbirth (*ibid.*: 13).

A recent survey by Diniz *et al.* (2014) in Brazil that interviewed 23,940 women that had given birth in public or private sectors has shown that around 75% reported having had a companion, although only 18% of this percentage was continuous companionship. In this research, women had a companion more frequently during admission and post-partum period (Diniz *et al.* 2014). In addition, having no companion or partial companionship was associated with using the public sector and having lower income and education (Diniz *et al.* 2014). This finding is consistent with the stories I heard, as Paola and Joyce were the only ones that had no companion with them during their childbirth, both giving birth in public hospitals. Diniz *et al.* (2014) also highlight that the presence of a companion was considered protective against abusive practices and physical or psychological violence during childbirth.

In the Brazilian booklet, on the top of the page 19 (*Figure 01*), there is a picture of a pregnant woman touching her belly. On her left, there is a headline in purple: "Labor"; under which there is a sub-headline: "Some things you should know to have a good birth". In the text under the sub-headline it can be read: "You have the right to a calm, private, ventilated and noiseless environment, only for you and your companion, during labor and birth. It is fundamental that you may be supported by people that bring you cheer and trust". On the next page (*Figure 02*), on the right side of the page, there is a purple headline "The birth". Under this headline there is a small text. On the first paragraph it can be read: "The birth is a great experience for the woman and baby, and also for the father. It can be a moment of great

pleasure: The exit of the baby, the end of the contractions and the meeting of this little being”. Under the whole text there is a picture of a woman being held by a man. She is holding a baby on her belly. The woman and the man are smiling. The baby is also being held by a third person’s hand.

Although the right for companionship obviously represents a major improvement, achievements should be interpreted with reservations. The Cochrane review in which both WHO, and the Brazilian research mentioned above are based on, underline some issues to take into consideration. While there is no doubt that any sort of companion during childbirth increases maternal satisfaction, the effectiveness in child-maternal outcomes remains unclear (Hodnett *et al.* 2011). There is evidence to support that companionship prevents interventions, such as cesarean sections, operative deliveries and epidural anesthesia (Hodnett *et al.* 2011). However, it is still uncertain if these outcomes would be observed if the support to the woman is given by a non-trained person, such as a family member or a friend (Hodnett *et al.* 2011). Hodnett *et al.* (2011) also make a note to policy makers and health administrators that it is possible that these expected outcomes do not become a reality if companionship is the only improvement in childbirth care.

Jessica, who had the opportunity of having her partner and her doula assisting her during labor and childbirth, mentioned the issue of companionship. She related that after her decision for a home birth had been made, her only fear was if she had to be transferred for some reason to the hospital:

I had the issue that if I had to go to the hospital, and this was something we had thought about a lot, long before we decided for the home birth, if I would go in [admitted at the hospital] with the doula or my boyfriend. Because you get a little... you need support. Thinking after I gave birth, if I had to choose between my doula and my boyfriend, I think both of us [she and her boyfriend] would have been abandoned together; because my boyfriend also needed a doula, not only me.

Tatiana, the doula I interviewed, mentioned that one of the main difficulties of her work is when women are forced to choose between their doulas or partners. Although Tatiana works mostly in private hospitals where women have their own room to give birth, most institutions impose restrictions to the number of companions. She told me:

Here in Curitiba, some hospitals very openly declare they don't like doulas. So women call their hospital to know: "I want to take my doula with me, so...?" Then some... No, not some, all of them say: "Okay, it is okay but then it will count as your companion. You have to choose between the father or the doula". How on earth is she going to choose that? So what they [women] do is to agree with the doctor. So, the hospital says what they want, but she had already planned with her doctor: "I'm going to take my doula, the father, and my sister together, okay?" [doctor:] "Okay." When the time comes the doctor puts everyone inside.

In the Brazilian survey by Diniz *et al.* (2014), most of the companions were family or friends and only 0.1% of companions were doulas. As mentioned before, although the percentages presented by this survey represent a huge improvement, that reportedly contributed to maternal satisfaction and prevention of abusive practices, I maintain that they should not be used to obscure the need for political willingness and resources to provide women continuous support that improves outcomes. The presence of trained professionals to provide reassurance and assistance to women and their partners is a requirement, if the changes promoted by the government ought to improve maternal mortality rates in the country.

In addition, some researchers in Brazil have suggested that one of the many causes contributing to the increase of cesarean sections is the possibility of knowing the doctor who will perform it (Béhague 2002). Most women in the private system have the possibility of choosing a doctor they trust. Some women I interviewed expressed a strong trust and reliability in their doctors, in a relationship that seemed to reassemble a friendship. Ana, who had a cesarean section in the private system, told me:

For me, there was two important moments during my birth. First, it was when the doctor came in. I was anxious, I was in pain, but suddenly I got in the surgical center... Lauro [husband] was not allowed; he would only come in after the anesthesia. I was alone. I was alone with a lot of people I did not know. I trusted these people, they were my doctor's staff, but I was alone. When she [her doctor] came in, when she came in I said: "Now, everything is fine. Now my child can be born because a person I trust, a person I like, whom I care for, she is here. She is here and I know she will do her best for me. (...) The second was when Lauro came in. When I heard his voice coming from the outside, I looked at her [doctor] and said: "If you want to cut me know, you can do it; because now, everything is okay. You are here; my husband is here".

This trust is significant, reasonable and described in the literature (McCallum 2005). The importance of providing women with a professional they trust to assist them during labor and childbirth, have evidence of promoting effective outcomes. In this line, issues of economic factors are also to be noted: While women from higher income classes, if they want they have access to doulas, or even the choice of a doctor they trust, this asset remains inaccessible to lower income women.

6.2.7 Anesthesia

The last practical feature I will discuss is the use of anesthesia during labor. The use of local anesthesia is common in Brazil, due to the high percentage of episiotomies (Brazilian Ministry of Health 2009: 162). Epidural anesthesia happens in around 30% of births in Brazil (Leal *et al.* 2014a). However, only around 30% of these epidural anesthetics happen in the public sector. Therefore, this procedure is more common among white women, with more years of education, and users of the private sector (Leal *et al.* 2014a). It came as a surprise to me that Alice was submitted to analgesia in the public hospital. She said:

The other one [the premature baby] was much easier for me. I got there almost getting [the baby], I didn't even have to push and it was born. I didn't even get analgesia. With Noah, even with analgesia, the one the doctor said that they gave it, it was much more difficult than the other.

Me: How was the anesthesia they gave you?

She: In the spine.

Me: When did they do it?

She: After I was fully dilated, when I was going to the table to get [the baby]. But I felt a lot of pain.

Me: *Did you feel pain even after the anesthesia?*

She: Yes. It hurts up to here [shows her legs], a lot of pain.

I observed that Alice mentioned that the anesthesia was administrated after her dilation was complete. Many of the women I interviewed that underwent prenatal care and childbirth in the private sector mentioned that anesthesia for labor, if required, would only be performed after a certain dilation, usually more than seven centimeters.

Ana had decided to have a cesarean section during the pregnancy, but spontaneously went into labor before the planned date. When admitted to the hospital, she was experiencing contractions for four hours and had dilated two centimeters. At the hospital, she received the information that anesthesia could only be given after seven centimeters. When her doctor arrived, the cesarean section was performed. She told me:

(...) I think it would have been a very long labor. Because four hours, two centimeters, that's too little! She [the doctor] told me that they wouldn't do any interventions during the labor, like medications, nothing before seven centimeters. I said: "No way! I won't wait that long!"

Epidural anesthesia during labor is controversial. Leal *et al.* (2104a), in an article about interventions in childbirth published after the most recent survey conducted in Brazil about childbirth, placed epidural analgesia during labor within the scope of 'unnecessary' procedures, alongside with Oxytocin use, amniotomy and episiotomy. This categorization of 'unnecessary' has received some criticism: a) All procedures classified as 'unnecessary', although overused in Brazil, have specific indications when they are 'necessary', and classifying them as 'unnecessary' was perhaps unfortunate (Cecatti 2014); b) the issue of determining if an epidural is 'necessary' or not requires further research and discussions about concepts and ethics in childbirth (Cecatti 2014).

There is no doubt that epidurals are effective in reducing pain during labor (Anim-Somuah *et al.* 2005, Leal *et al.* 2014, WHO 1996), and among other pharmacological

techniques it is the most used worldwide (WHO 1996). In addition, there is strong evidence to say that the main unwanted effects of epidurals are the increase of labor duration and the onset of instrumental vaginal delivery (Anim-Somuah *et al.* 2005, Leal *et al.* 2014, WHO 1996). WHO supports the evidence that increased rates of operative deliveries happen when epidurals are performed before five centimeters dilation (WHO 1996: 15), which may explain the practice mentioned by the women I heard about epidurals being performed only close to full dilation. However it is still unclear if epidurals can be associated with the increase of cesarean sections (Anim-Somuah *et al.* 2005, Leal *et al.* 2014). In addition, although no short effects were found in maternal or child outcomes, there is a suspicion of long-term effects, in need for further research (Leal *et al.* 2014). Also, the present data has not shown any association between maternal satisfaction with birth event and the use of epidural anesthesia (Anim-Somuah *et al.* 2005, Leal *et al.* 2014).

In the Brazilian booklet, there is no mention of epidural analgesia. Information about pain however can be found on page 20, under the purple headline “The birth”(Figure 2), above the picture of the women and the man with the baby, on the second paragraph (the first paragraph has been discussed in section 2.6): “You must have heard many things about pain in childbirth. It is important to know that this pain varies from woman to woman, and that it is greater if the woman is tense or afraid”. This sentence is the main reference to labor pains in the booklet, except for the recommendation of shower or baths to alleviate the pain, as I have described earlier. It seems it is women’s role to find inner calm, to relax and avoid stress or fear, and so to handle the pain.

WHO supports the use of epidurals only in cases of complicated deliveries, stressing the need for a well-equipped hospital if this pharmacological procedure needs to be performed (WHO 1996: 16):

There is little doubt that epidural analgesia is useful in complicated labor and delivery. However, if epidural analgesia is administered to a low-risk pregnant woman, it is questionable whether the resulting procedure can still be called “normal labor”. Naturally, the answer depends on the definition of normality, but epidural analgesia is one of the most striking examples of the medicalization of normal birth, transforming a physiological event into a medical procedure. The acceptance of this transformation is largely determined by cultural factors.

To take further the discussion about the use of epidurals to handle the pain in childbirth, I would like to return to the analyses on pain in Chapter Five. I have previously discussed the symbolical place of pain as a mark of ownership and control over the birth event. This implication seems to emerge in WHO’s manual, where epidurals represent the line that separates the physiological birth from the medical one. When epidurals are used, instruments, machines and interventions come along. It requires hospital structure and resources. WHO brings up the question if this mode of childbirth, with machines and instruments, requiring medical management, could be termed ‘normal’. ‘Normality’ in childbirth seems to be defined in WHO’s manual in terms of protection and maintenance of the body physiology by the absence of interventions, assuming that this physiology is lost when certain procedures, as for instance epidurals, are made. What becomes foregrounded by this logic is the production of a ‘normal’ birth and its counterpart, the ‘abnormal’ birth, where normality is marked by the absence of interventions while medical procedures determine abnormality.

As explored already, in Foucault’s theory power, ‘normality’ is a state that it is not imposed as a rule to be followed by the individual, rather it is desirable from the inside (Mol 2002: 58). According to Foucault, ‘normalization’ is one of the greatest instruments of power (Foucault 1979: 184), because those classified as ‘abnormal’ are marginalized to the fringes of society (Mol 2002: 58). Thus, normality is voluntarily sought. In Foucault’s conceptualization of power, it is medicine as an institution that articulates what it is to be ‘normal’ and to behave in a ‘normal’ way (Mol 2002: 57-58). Thus, it is medicine that sets the limits between physiology and disease. Abnormality and disease are not desirable. To the

discussion about pain, Foucault's theory can be applied in WHO's recommendation to avoid epidurals in low risk births, in order to maintain its physiology. As a medical institution, WHO exercise a normative power, by providing standards and limits between a physiological and 'abnormal' birth. A decision for an epidural becomes a moral endeavor, since a pursuit for normality corresponds to a proper behavior. The 'normal' birth becomes the desirable mode of birth, kept within the limits of normality by avoiding interventions.

6.3 A Path to Conclusion

Throughout this chapter I have discussed some of the practices described by Alice in her narrative of a 'normal' birth, relating them to governmental advices for 'humanization' of childbirth as presented in a booklet published by the Brazilian Ministry of Health. Since the practices promoted by the government within this program are said to be evidence based (Diniz 2005, Misago *et al.* 2001, Tornquist 2002), I have also looked into some research on the topic, especially studies presented by the World Health Organization (WHO).

It is clear, as Alice's and other women's narratives have shown, that the reality women experience in practice when giving birth differs greatly from recommendations made by the Brazilian government or WHO. This finding is consistent with recent research in Brazil (Leal *et al.* 2014). However, while WHO is an institution that occupies the role of gathering information and providing guidelines, governments, in this case the Brazilian government, are accountable for implementing such measurements and transforming the practices in the country. Although WHO's recommendations for 'normal' birth were published in 1996, and the Brazilian government's program for 'humanization' with the purpose of changing the way birth is done in the country was implemented in 2000, most of the guidelines remain unmet in the hospitals women give birth at in Brazil. Based on the issues analyzed in this chapter, it is relevant to discuss the government's actions and public health strategies.

It is important to reflect upon the consequences of providing women with

recommendations that will not be met in practice. I fail to recognize the purpose of providing women with advice that cannot be followed once they are admitted in a hospital. I argue that this strategy is a reflex of the government's aim of empowering women through enhancing their participation on the birth event - a result of feminist pressure - as discussed in previous chapters. However, from my own findings it seems clear that women have none or little autonomy in the birthing setting, especially in the public sector. Women I talked to subjected themselves to procedures that seemed to be the norm, and hospitals did not seem to allow much negotiation of policies or regulations. This finding is consistent with literature on maternal health in Brazil (Leal *et al.* 2014, McCallum 2005). Women in the private sector have also shown to have limited autonomy. Although most of them start their pregnancies aiming for a vaginal birth, the outcome is often a cesarean section (Barbosa *et al.* 2003, Hopkins 2000, Potter *et al.* 2008). Since most women that subject themselves to a cesarean section do so assured that some sort of risk is being prevented by the surgical procedure, it has been questioned to which extent this deliberation represents women's autonomy (Béhague 2002, McCallum 2005). Manuela's narrative featured an illustration of this issue. However, it became also clear to me that some women do choose cesarean sections without any clear medical indication, as observed for instance in Ana's, Meline's and Maria's stories. An authentic choice for a cesarean section however, is the prerogative of high income women who can afford private care.

I claim that although childbirth in Brazil is a hot topic, and vaginal childbirth has been promoted with the purpose of fostering women's autonomy, a concrete right for self-governance is likely to remain unmet due to Brazilian well-known social and economical inequalities. If statistical data up to the present date is taken into account, in overall, normal births that happen in the public sector are associated with lower income women, and cesarean sections in the private sector to higher income - and well-educated women (Béhague *et al.* 2002, Leal *et al.* 2014, Victora *et al.* 2011). It was extensively pointed to me by the women I

interviewed that the rates of cesarean sections are lower in the public sector because women there are not granted the right to choose a cesarean section. If women in Brazil come to embrace 'natural' or 'humanized' ways to give birth, as it has been promoted by the government and international health organizations, it will likely remain the case that only high-income women will be granted the right to choose doing it or not. While 'humanization' reaches high-income women through changes of their views and perspectives on birth, to low-income women it materializes through hospital policies.

Even if all public hospitals in the country adopt 'humanized' practices, low-income women will still remain not being able to give birth at hospitals of their own choice, or granted the option to ask for an epidural, and as a consequence being subjected to whatever regulation the hospital has adopted. If 'humanization' becomes the norm, women that can afford private care will always be granted the choice for a cesarean section or an epidural, whilst low-income women remain dependent on the government's provision of the best scientific based practices. There is no doubt that the care provided to women giving birth in Brazil is in need for a strong reform, and it seems that it follows a path towards improvements. However, it remains highly problematic if 'humanization' becomes compulsory, by the same grounds that 'medicalization' became the norm. In this line of thoughts, I agree with Kukla's (2005: 223-224) argument:

The 'medicalization' of pregnancy, birth, and mothering is not, in and of itself, what renders these processes alienating, violating, and self-erasing for many women. Rather, the threats to mothers' embodied self devolve, I would claim, from our social and medical refusal to grant their boundaries the same solidity and their domain of privacy the same integrity as those of other citizens. In this refusal, contemporary versions of medical interventionism and the rhetoric of the 'natural' equally collude.

By no means do I intend to argue that Brazil should not pursue a reduction of cesarean section rates, not do I imply that recommended practices by WHO should not be followed. Rather I suggest that although it still remains uncertain the extent to which the elevated

cesarean section rates influence maternal mortality (Althabe *et al.* 2006, Morrison and Mackenzie 2003), there is no doubt that interventionist births represent enormous extra costs (Gibbons *et al.* 2010, Villar *et al.* 2006). I argue however, that a refusal to grant women the right to choose cesarean sections or epidurals on basis of income reveals Brazil's socio-economic disparities as well as deep ethical issues with regards to violations of reproductive rights. While women giving birth in the private sector and who choose to experience the pain in childbirth - which will likely increase if nowadays promotion of 'humanization' is proven effective - have access to doulas, bathtubs and private rooms, this is not the case for women giving birth in the public sector. Although initiatives to provide these measurements in the public sector do exist, it is very unlikely that bathtubs and doulas become a general practice granted to all women in the country. The practice in Brazil is that most low-income women give birth without pain medications under the label 'recommended by WHO', and they do so without any other alternatives to overcome the pain. In this setting, if not performed as a choice, the picture of the empowered woman giving birth in the upright position without pain medication loses its essence, since she is not granted her right of self-governance.

This chapter has shown the contrasts between the practices experienced by women when giving birth, and the advises promoted by the Brazilian Ministry of Health through a booklet provided to all pregnant women in the country. These advises were compared with relevant literature, in particular WHO's official manuals. The advises of the Brazilian Health Ministry reveal a tendency to support 'natural' measures when giving birth and during childbirth deliveries, opposing interventionist procedures that, in practice, are experienced by the majority of women in Brazil.

CHAPTER SEVEN: ENDING REMARKS

She doesn't do the normal birth because she wants. For real, she would like to do a cesarean, but she does not, because she doesn't have the means...

Joyce, who had a normal birth in the public system

Childbirth happens in women's bodies. Through descriptions of events experienced by the women I interviewed I have argued in this thesis that the practice of childbirth in Brazil happens within a medical view of the body. Michael Foucault's theory of power/knowledge has laid the foundation to claim that the power of medicine is a productive force, which exists through the practices pregnant and laboring women subject themselves to. These practices work to produce women's bodily experiences, as well as to produce the kind of health care that is provided for them. In addition, I have based my arguments on contemporary philosophers, such as Barbara Duden and Rebecca Kukla, to explore how the production of the maternal body as it is experienced in Brazil shares roots with the development of western medicine.

I have shown that the practices of childbirth in Brazil are deeply influenced by concepts developed in the last century, namely the 'medicalization' critique and the 'natural' childbirth movement. I have demonstrated that especially through the impact of feminist movements in the country, childbirth has acquired a condition as 'medicalized' phenomenon. As the critical theory of 'medicalization' portrays medicine as an oppressive power that undermines social human phenomena, it calls for concrete measures to challenge the power embedded in bio-medicine. I have demonstrated that childbirth in Brazil is often described as highly 'medicalized', and the high rates of cesarean section in the country often feature as the main example. Therefore, it is mainly by the action of feminist movements that policies and measures came about contributing to a change in the way childbirth is conducted in the country, expected to reduce the rates of cesarean sections. As I have shown, these policies

have emerged as a response to the encompassing ‘medicalization’ of women’s bodies highlighted by the ‘medicalization’ critique. These policies reflect a pressure to return the childbirth event back to the women themselves, and as such challenging the medical hegemony.

The notion of ‘humanization’ of childbirth, and the governmental programs that support this notion have, as discussed in this thesis, clearly shown a movement in Brazil towards a ‘de-medicalization’ of childbirth. The practices promoted by the Brazilian government and advocates for ‘humanization’ express core values of worldwide movements to ‘naturalize’ childbirth. These practices, described and experienced by the women I interviewed, reveal a notion of childbirth as a ‘physiological’ and ‘natural’ event, in need to be protected from medical interventions. In general, baths, showers, massages, Swiss ball, upright position, squatting position, walking, touching or seeing the baby’s head in the expulsive period, and the presence of a companion were described as ‘natural’, and therefore not capable of corrupting the birth physiology. In contrast, Oxytocin, anesthesia, episiotomy, cesarean sections, hospital environments and being left alone were portrayed as medical interventions that interfere with the birth physiology, pushing this event into the medical domain.

I have argued that ‘medicalization’ and ‘naturalization’ are parallel movements: At the same time opposing and reinforcing each other. Although it is immensely relevant to recognize the improvements the notion of ‘humanization’ contributes to in Brazil, I have contended that the consequences of policies and recommendations that support this view have had far reaching effects. In this thesis I have shown two main problems related to these effects: a) The polarization of opinions and discussions; b) the polarization of health care towards pregnant and laboring women.

The first problem in the promotion of ‘humanization’ is that it has created a clear cut between two birth categories: The ‘medical’ and the ‘natural’. The efforts to reduce the rates of cesarean section in Brazil have made this topic a hot one in academic settings, as well as in

Brazilian society at large. I have shown that ‘humanization’ is often described as the main model to tackle this issue. However, I have demonstrated that this notion is deeply associated with ‘natural’ ways of giving birth, contrasting the highly ‘medicalized’ cesarean births. In the ‘natural’ moral ontology, any medical procedure may corrupt the physiology of birth. I have argued that while ‘humanization’ is intended to promote a more comprehensive care towards women, it has overlooked the trust and hope many may place in medical interventions. In Brazil, a setting where the majority of births happen in a hospital, and more that half happen by means of cesarean sections, advocacy to ‘de-medicalize’ the birth event is looked upon by many women with distrust. I claim that instead of promoting a middle path, the notion and the policies for ‘humanization’ have placed Brazilian society in two opposite poles: Those favoring ‘natural’ births opposing those who doubt its reliability.

The second issue related to ‘humanization’ is the practical repercussions in the care towards women in the Brazilian setting. Throughout this thesis I have argued that if childbirth is only experienced within a medical view of the body, it makes no sense to claim for a divide between ‘medicalized’ and ‘natural’ childbirth. I contended that both categories fall into our western requirement to control the phenomenon of birth, born long before the divide ‘medical’/‘natural’ was developed. Women I interviewed subjected themselves to either category, and by doing so fulfilled a demand for proper regulation and monitoring.

The practices of childbirth described in this thesis show that Brazilian maternal health care delivery is characterized by disparities between the public and the private health sectors, and by consequence between low and high-income women. Presently, cesarean sections can be a choice for women using the private system, but not for those giving birth in the public system. While ‘humanization’ represents an alternative for high-income women that use the private sector, for low-income women, ‘humanization’ is translated into policies and regulations they have to submit themselves to in public hospitals. In the same way that cesarean sections are not provided on demand in the public sector, due to national policies

aimed at reducing the rates, anesthesia for vaginal birth is very rare under the label ‘humanization’ of care. While women that can afford it will be provided with bathtubs, doulas and a private room, it is questionable if these features can ever be available to the majority of Brazilian women that have their babies through SUS. While a ‘natural’ childbirth can be such a powerful experience to a woman given her freedom of choice, it is as violating if performed in absence of entitlements. I have argued that in this refusal to grant low-income women their right for self-governance both ‘medicalization’ and ‘humanization’ serve to infringe on Brazilian women’s reproductive rights.

It is important to emphasize however, that the discussions throughout this thesis do not seek to devaluate the efforts and achievements of those urging for respect and changes in the way health care is provided to pregnant and laboring women in Brazil. On the contrary, the findings of this research show that despite considerable improvements the past decade, there is still much to be accomplished if we ought to untangle the firm web of social inequalities in the country. Moreover, the discussions presented throughout this dissertation reveal that the notion of ‘humanization’ in fact, has created ripple effects that were perhaps not originally intended. This finding exhort policy makers to reconsider the polarized approach in public health strategies, promoting a more neutral setting where institutions, health professionals and women are able to contemplate common intents and interests.

Above all, the findings discussed in this thesis emphasize the need for continuous research on childbirth and maternal health in Brazil. It became transparent in many of the stories I heard that the relationship between women, professionals and institutions is determinant to enable the quality of care, much more so than the procedures performed. It still remains unanswered how this relationship can be promoted and turned into practice. My findings suggest that a focus on human resources may produce beneficial outcomes, bringing about the changes in childbirth care aspired by the Brazilian government and society, without violating women’s boundaries.

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Appendix 1: Regional Committees for Medical and Health Research Ethics letter



Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord			05.09.2013	2013/1198/REK nord
			Deres dato:	Deres referanse:
			25.06.2013	

Vår referanse må oppgis ved alle henvendelser

Benedikte Victoria Lindskog

2013/1198 Fødsler og keisersnitt i Brazil

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 22.08.2013. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikklovens § 4.

Forskningsansvarlig: Institute of Health and Society
Prosjektleder: Benedikte Victoria Lindskog

Prosjekttale

Cesarean section is a surgical intervention used as a life saving procedure in order to prevent morbidity and mortality. Emphasizing that the intervention is beneficial to some extent, researchers draw attention to potential harm attached to its overuse. WHO's suggestion of a 15% upper limit remains the best known recommendation. In Brazil, the level reaches a 45.6% rate of this intervention among all births. In recognition of the numbers above 15% denoting the amount of women being exposed to this major surgery perhaps in absence of need, it is appropriate to consider high CS rates as a public health matter in Brazil. Still, this issue can never be considered as a public health matter alone. CS as a common event gives weight to the conceptualization of birth. Hence, becoming culturally and socially relevant. This research will seek to explore childbirth as a phenomena, thrust in the social-cultural context of high cesarean section (CS) rates in Brazil.

Vurdering

Framleggingsplikt

De prosjektene som skal framlegges for REK er prosjekt som dreier seg om "medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger", jf. helseforskningsloven (h) § 2. "Medisinsk og helsefaglig forskning" er i h § 4 a) definert som "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Det er altså formålet med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

I dette prosjektet ønsker man å se på fødsler i lys av at Brasil har en stor andel fødsler som skjer ved keisersnitt. Prosjektet skal ikke vurdere eventuelle medisinske årsaker, men fokuserer på kvinnes refleksjoner og erfaringer.

Komiteen anser at forskningsprosjektet vil fremskaffe kunnskap og belyse sosiologiske forhold, men anser ikke at prosjektet vil gi ny kunnskap om helse og sykdom. Prosjektet skal således ikke vurderes etter helseforskningsloven.

Besøksadresse:
MH-bygget UiT Norges arktiske
universitet 9037 Tromsø

Telefon: 77646140
E-post: rek-nord@asp.uit.no
Web: <http://helseforskning.etikkom.no/>

All post og e-post som inngår i
saksbehandlingen, bes adressert til REK
nord og ikke til enkelte personer

Kindly address all mail and e-mails to
the Regional Ethics Committee, REK
nord, not to individual staff

Vedtak

Etter søknaden fremstår prosjektet ikke som et medisinsk og helsefaglig forskningsprosjekt som faller innenfor helseforskningsloven. Prosjektet er ikke fremleggingspliktig, jf. helseforskningslovens § 10, jf. forskningsetikkloven § 4, 2. ledd.

Klageadgang

Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK nord, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Kopi til: linda.andreassen@medisin.uio.no; postmottak@medisin.uio.no

Appendix 2: Norwegian Social Science Data Service letter

Norsk samfunnsvitenskapelig datatjeneste AS

NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Harald Hårfagres gate 29
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Benedicte Lindskog
Institutt for helse og samfunn
Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 30.09.2015

Vår ref: 44213/3/IMHM

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 14.08.2015. All nødvendig informasjon om prosjektet forelå 30.09.2015. Meldingen gjelder prosjektet:

44213	<i>Birth and cesarean section in Brazil</i>
Daglig ansvarlig	<i>Benedicte Lindskog</i>
Student	<i>Carolina Borges Rau Steuernagel</i>

Personvernombudet har registrert at datainnsamlingen allerede er gjennomført. I telefonsamtale 30.09.2015 informerer studenten at datamaterialet nå er anonymisert. Personvernombudet minner om at institusjonen er ansvarlig for at prosjekter som omfattes av meldeplikten meldes senest 30 dager før oppstart.

Personvernombudet har vurdert prosjektet på bakgrunn av den informasjon vi har fått om gjennomføringen, og finner at behandlingen av personopplysninger var omfattet av meldeplikten iht. personopplysningsloven § 7-27.

Ettersom det ikke lenger behandles personopplysninger i prosjektet, kan personvernombudet ikke realitetsbehandle meldeskjemaet. På bakgrunn av den informasjon vi har fått om prosjektet, mener vi imidlertid at det har vært gjennomført på en god måte og i tråd med personopplysningslovens øvrige bestemmelser (når vi ser bort fra bruddet på meldeplikten).

Siden det per i dag ikke behandles personopplysninger avslutter vi saksbehandling av meldeskjemaet uten realitetsbehandling. Vi avslutter også all oppfølging av prosjektet.

Ta gjerne kontakt dersom noe er uklart.

Vennlig hilsen


Katrine Utaaker Segadal


Marianne Høgetveit Myhren

Kopi:
Carolina Borges Rau Steuernagel, Lyder Sagens gate, 7, 0358 OSLO

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